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RETIREE HEALTH BENEFITS

MF 11 ORIGINAL

HEARING

BEFORE THE

SUBCOMMITTEE ON SAVINGS, PENSIONS, AND INVESTMENT POLICY

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 9, 1985

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POST-RETIREMENT HEALTH BENEFITS

MONDAY, SEPTEMBER 9, 1985

U.S. Senate, e,
Subcommittee on Savings, Pensions
and Investment Policy,
Committee on Finance,
Washington, DC.

The subcommittee met, pursuant to notice, at 3 p.m. in room SD-215, Dirksen Senate Office Building, the Honorable John Heinz (chairman) presiding.

Present: Senators Heinz and Mitchell.

[The press release announcing the hearing, the prepared statements of Senators Heinz and Mitchell, and a report by the Joint Committee on Taxation follow:]

[Press Release No. 85-063, Wednesday, Aug. 7, 1985]

Retire Health Benefits Hearing Reset by Finance Subcommittee

The Senate Committee on Finance's Subcommittee on Savings, Pensions and Investment Policy has rescheduled its hearing on problems being encountered by the nation's employers in the funding of retiree health benefits.

The topic is to be discussed by the Finance Subcommittee at a hearing Monday, September 9, 1985, beginning at 2 p.m.

Senator Bob Packwood (R-Oregon), Chairman of the Committee on Finance, said: Senator John Heinz (R-Pennsylvania), Chairman of the Subcommittee on Savings, Pensions and Investment Policy, would preside at the hearing.

The Subcommittee will specifically examine employer problems in the funding of retiree health benefits as well as the effects the Deficit Reduction Act of 1984 has had, and is having, on the funding incentives for such benefits, Chairman Packwood said.

Opening Statement of Senator John Heinz

The problems we are to consider is one with serious consequences for the income and well-being of retired workers and their families now and in the future. Simply stated, the problem is that employers have promised nearly $200 billion in health benefits for workers in retirmement which they have not yet begun to fund. Unfunded liabilities of this magnitude are a source of insecurity not only to the retirees who need these benefits, but to the employers who must pay for them. With rising health insurance costs and growing concerns about these liabilities, many employers are searching for ways to either fund these benefits or cut back on their promise of health coverage.

Congress made matters worse last year by eliminating the tax advantages for VEBAs which employers had just begun to use to pre-fund the retiree health. While the concern that VEBAs were ripe for abuse was legitimate, the shutdown of the VEBA mechanism left employers high and dry in their efforts to fund retiree health liabilities. Worse yet, it left the 9 million retirees with benefits and the millions of workers still to come with no hope of making these vital health benefits more secure.

Finding a way to secure post-retirement health benefits must be an integral part of our efforts to bring greater income security to America's elderly. It is my hope that these hearings today will give us a greater understanding of the problem and a clearer sense of the solutions.

Specifically, we would like to hear comments from our witnesses today on whether employers should be permitted to pre-fund retiree health benefits in a tax-favored fund, and whether Congress should mandate funding as a condition for providing these benefits. We would also like to know what kinds of benefit guarantees for workers and retirees should be attached to any funding vehicle. Finally, we would be interested in hearing the comments of the witnesses on the funding options that we should consider—should we reinstate the VEBA or come up with something new?

The Senate Special Committee on Aging, which I chair, has recently released an information paper on funding of post-retirement health benefits. Without objection, I would like to enter a copy of this paper into the record for this hearing.

I am pleased that Mr. Ross from the Treasury Department could be here this morning. The Treasury and the Department of Labor have been hard at work on a study of the funding needs of retiree health plans, and the means of providing minimum standards for employee participation, vesting, and funding of these benefits. Mr. Ross, I know you can't provide us with the results of your study yet, but I am glad you could be here anyway to give us Treasury's view on the issues.

OPENING STATEMENT OF SENATOR GEORGE J. MITCHELL

I am pleased Senator Heinz has called this hearing to explore some of the tax and spending issues involved with employer provided health care benefits for retirees.

This is a complex issue that will require delicate Congressional review. Employer provided health benefits are becoming an increasingly important source of health protection to retirees. The federal government has a great interest in insuring that these benefits continue to be provided on a fair and nondiscriminatory basis to the maximum number of retirees.

At the same time, employers are becoming increasingly concerned for the growing cost of these benefits and are beginning to reassess their obligation to provide benefits.

While most of us can probably agree that there is a need for federal tax and regulatory rules to govern retiree health benefits, many questions remain about just what is needed. Congress must not only be concerned for the direct impact on Medicare costs but also the indirect implications this issue could have on federal revenues. Employers are understandably wary of federal regulation of these benefits and want to ensure that these costs are properly reflected for tax purposes.

The stakes are high. This issue will grow in importance in the years ahead and now is the time for intensive Congressional review. I look forward to receiving the testimony today to learn more about this issue.

DESCRIPTION OF PRESENT LAW TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH BENEFITS

Scheduled for a Hearing

Before the

SUBCOMMITTEE ON SAVINGS, PENSIONS
AND INVESTMENT POLICY

of the

COMMITTEE ON FINANCE

on September 9, 1985

Prepared by the Staff

of the

JOINT COMMITTEE ON TAXATION

September 6, 1985

JCX-15-85

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INTRODUCTION

The Senate Finance Subcommittee on Savings, Pensions and Investment Policy has scheduled a public hearing on September 9, 1985, on employer funding of retiree health benefits. This Subcommittee hearing was rescheduled from the previous date of July 29, 1985.

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of present law tax treatment of employer-provided health benefits.

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[1] This document may be cited as follows: Joint Committee on Taxation, *Description of Present Law Tax Treatment of Employer-Provided Health Benefits* (JCX-15-85), September 6, 1985. (This document is an updated reprint of JCX-10-85, prepared for the previously scheduled Subcommittee hearing. There is no substantive changes from JCX-10.)

TAX TREATMENT OF EMPLOYER-PROVIDED HEALTH BENEFITS

A. Overview

Present law provides a number of tax benefits to encourage employers to provide health benefits to their employees. Employer contributions to a plan providing accident or health coverage generally are excludable from gross income. Certain benefits actually paid under such plans are also excludable from the employee's income. Employer contributions to fund medical benefits are deductible, within limits. If such benefits are prefunded through a nondiscriminatory welfare benefit fund or qualified pension plan, employers may claim deductions for additions to qualified reserves. Additional contributions are permitted to be made on a deductible basis to provide post-retirement health benefits for former employees. These deductible reserves are also permitted to accumulate in a trust exempt from income tax and, in part, from the unrelated business income tax.

Gross income, for income tax purposes, includes "all income from whatever source derived" (Code sec. 61(a)). This provision "is broad enough to include in taxable income any economic or financial benefit conferred on the employee as compensation, whatever the form or mode by which it is effected" (Comm'r v. Smith, 342 U.S. 177, 181 (1945)).

As a general rule, if an employer-provided fringe benefit program qualifies under a specific statutory provision of Federal income tax law, then the benefits provided under the program are excludable (generally, subject to dollar or other limitations) from the employee's gross income for income tax purposes. The costs of benefits that are excluded from the employee's income nonetheless are deductible by the employer, provided that they constitute ordinary and necessary business expenses (sec. 162). The income tax exclusions also generally apply for employment tax purposes.

B. Exclusion for Employer-Provided Medical Benefits

Under present law, an employer's contributions to a plan providing accident or health benefits are excludable from the employee's income (sec. 106). No similar exclusion is provided for self-employed individuals (sole proprietors or partners).

Benefits actually paid under accident and health plans generally are includible in the employee's gross income to the extent attributable to employer contributions (sec. 105(a)). However, payments unrelated to absence from work and reimbursements for costs incurred for medical expenses (within the meaning of sec. 213) are excluded from gross income (sec. 105(b)). In the case of a self-insured medical reimbursement plan (sec. 105(h)), no exclusion is provided for benefits paid to any employee who is among the five highest-paid officers, a 10-percent shareholder, or among the 25-percent highest-paid employees if the program discriminates in favor of this group as to either eligibility to participate or the medical benefits actually provided under the plan.

C. Limits on Employer Deductions to Fund Medical Benefits

In general

Effective for contributions made after December 31, 1985, the amount of the deduction otherwise allowable to an employer for a contribution to a welfare benefit fund for any taxable year is not to exceed the qualified cost of the fund for the year. The qualified cost of a welfare benefit fund for a year is defined as the sum of (1) the qualified direct cost of the fund for the year and (2) the addition (within limits) to reserves under the fund for the year (the qualified asset account), reduced by the after-tax income of the fund.

A fund is defined as any tax-exempt social club, voluntary employees' beneficiary association (VEBA), supplemental unemployment compensation benefit trust (SUB), or group legal services organization; any trust, corporation, or other organization not exempt from income tax; and, to the extent provided by Treasury regulations, any account held for an employer by any person.

Qualified direct cost

The qualified direct cost for a taxable year is the aggregate amount (including administrative expenses) that would have been allowable as a deduction to the employer with respect to the benefits provided by the fund during the taxable year, if the benefits had been provided directly by the employer, and if the employer had used the cash receipts and disbursements method of accounting. For example, in the case of a self-insured medical reimbursement plan, the qualified direct cost equals the actual benefit payments made to employees for the taxable year, plus the administrative costs of providing such benefits.

Qualified asset account

The qualified asset account under a welfare benefit fund consists of the value of assets set aside to provide for the payment of disability benefits, medical benefits, supplemental unemployment compensation benefits (SUB), severance pay benefits, or life insurance (including death) benefits. Present law provides an account limit with respect to the amount in the qualified asset account for any year. Additions to a qualified asset account in excess of the account limit for a year do not increase qualified cost and, therefore, are not deductible for the year.

The account limit for a qualified asset account for a taxable year is generally the amount reasonably and actuarially necessary to fund claims incurred but unpaid (as of the close of the taxable year) for benefits with respect to which the account is maintained and the administrative costs incurred with respect to those claims. Claims incurred but unpaid include claims incurred but unreported as well as claims reported but unpaid.

Unless there is an actuarial certification of the account limit for a taxable year, the account limit for the year is not to exceed the sum of the safe harbor limits for the year. Accordingly, an actuarial certification by a qualified actuary (determined under Treasury regulations) justifying the taxpayer's reserve computations is necessary if the amount in the qualified asset account is above a prescribed safe harbor level equal to the sum of the separate safe harbor amounts computed with respect to each benefit.

For medical benefits (including post-retirement medical benefits), the safe harbor limit for a taxable year is 35 percent of the qualified direct cost (including administrative costs) of providing the benefit for the immediately preceding taxable year.

Post-retirement medical benefits

Special account limits are provided for post-retirement medical benefits. Those limits allow amounts reasonably necessary to accumulate reserves under a welfare benefit plan so that funding of post-retirement medical benefits with respect to an employee can be completed upon the employee's retirement. These amounts may be accumulated no more rapidly than on a level basis over the working life of an employee with the employer of that employee. Funding is considered level if it is determined under an acceptable funding method so that future post-retirement benefits and administrative costs will be systematically allocated ratably to future pre-retirement years.

Each year's computation of contributions with respect to retiree medical benefits is to be made under the assumption that the medical benefits provided to retirees will have the same cost as medical benefits currently provided to retirees. Because the reserve is to be computed on the basis of current medical costs, future inflation is not to be taken into account and it is to be assumed that the level of utilization will not increase in the future. Accordingly, future experience is not to be assumed to be less favorable than past experience.

No deduction for advance funding is allowed with regard to a plan which provides medical benefits exclusively for retirees, because such a plan would be considered a plan of deferred compensation rather than a welfare benefit plan. If a plan maintained for retirees is merely a continuation of a plan maintained currently or in the past for active employees, then the retiree plan would not be considered a plan of deferred compensation because medical benefits would have been provided without the necessity of retirement or other separation from service.

In addition, no reserve is to be taken into account in computing the account limit with respect to post-retirement medical benefits under a plan that does not meet the nondiscrimination rules applicable to such benefit.

Separate accounts for certain post-retirement benefits

Present law provides an overall limit with respect to pre-retirement deductions for the retirement benefits of employees to insure that the effect of any prefunding of these benefits is nondiscriminatory. Under this limit, separate accounting is required with respect to amounts attributable to contributions made to a welfare benefit fund under the provisions for additional reserves for post-retirement benefits. Separate accounting is required for contributions, under the post-retirement reserve provisions, to provide medical benefits to an individual who is, or ever has been, a key employee.

The amount of medical benefits provided under the plan after retirement to an employee with respect to whom these requirements are in effect is limited to the balance in the employee's separate account. Present law also provides for the coordination of net contributions for post-retirement medical benefits with the overall limits on contributions and benefits under section 415(c) and (e); any such amount allocated to a separate account is to be treated as an annual addition to a defined contribution plan.

D. Tax on Unrelated Business Income

Tax-exempt organizations generally are subject to income taxes on income from an unrelated trade or business. In the case of a voluntary employees' beneficiary association (VEBA) (sec. 501(c)(9)), income of the organization generally is not subject to the tax on unrelated business income to the extent that the income is exempt function income consisting of certain member contributions and amounts set aside to provide permissible benefits.

A specific annual limit applies to the amount of income of a tax-exempt VEBA, or supplemental unemployment compensation benefit trust (SUB) (described in sec. 501(c)(9) or (17), respectively) that may be considered a permissible set aside. The amount of such an organization's income for a year that may be considered set aside as exempt function income is generally not to increase the total amount that is set aside to an amount in excess of the account limit for the taxable year determined under the deduction limits.

For purposes of determining the limit on the set aside, the account limit generally is not to include any amount with respect to reserves to provide post-retirement medical benefits. However, the limit on the amount which may be set aside for purposes of the unrelated business income tax does not apply to income attributable to certain existing reserves for post-retirement medical benefits. This exclusion applies only to income attributable to the amount of assets set aside, as of the close of the last plan year ending before July 18, 1984, for purposes of providing such benefits.

E. Excise Tax on Disqualified Benefits

If a welfare benefit fund provides a disqualified benefit during a taxable year, then an excise tax is imposed for that year on each employer who maintains the fund. The tax is equal to 100 percent of the disqualified benefit.

A disqualified benefit is (1) any post-retirement medical or life insurance benefit provided by a welfare benefit fund with respect to a key employee other than through a separate account for that employee, (2) any post-retirement medical or life insurance benefit provided to highly compensated employees under a plan of which the welfare benefit fund is a part that does not meet nondiscrimination requirements with respect to the benefit, or (3) any portion of the fund that reverts to the benefit of the employer (whether or not all liabilities of the fund have been previously satisfied).

F. Medical Benefits Provided by Qualified Plans

Present law also permits an employer to pre-fund post-retirement medical benefits through a tax-qualified pension or annuity plan provided certain additional qualification requirements are met with respect to the post-retirement medical benefits. First, the medical benefit, when added to any life insurance protection provided under the plan, must be subordinate to the retirement benefits provided by the plan.

Second, a separate account must be maintained with respect to contributions to fund such benefits. This separate accounting is determined on an aggregate, rather than a per participant basis, and is solely for recordkeeping purposes. Third, the employer's contributions to a separate account must be reasonable and ascertainable. Fourth, the plan must preclude the application of amounts in the separate account, at any time prior to the satisfaction of all liabilities with respect to post-retirement benefits, to any other benefits. Upon the satisfaction of all plan liabilities to provide post-retirement medical benefits, the remaining assets must revert to the employer and cannot be distributed to the retired employees. Similarly, if an individual's right to medical benefits is forfeited, the forfeiture must be applied to reduce the employer's future contributions for post-retirement medical benefits.

In addition, for years beginning after March 31, 1984, if the requirements with respect to post-retirement medical benefits are met, employer contributions to fund these benefits are deductible under the general rules relating to deductions for contributions to qualified plans. The deduction for such contributions is in addition to the deductions provided for contributions for retirement benefits. The amount deductible may not exceed the total cost of providing the medical benefits, determined in accordance with any generally accepted actuarial method that is reasonable in view of the provisions and coverage of the plan, the funding medium, and any other relevant considerations. In addition, for years beginning after March 31, 1984, any pension plan that provides such benefits is required to create and maintain an individual medical benefit account similar to that required in a welfare benefit fund for any participant who is a 5 percent owner and to treat contributions allocated to such accounts as annual additions for purposes of the overall limits on contributions and benefits.

G. Study of Employee Benefit Plans

In enacting provisions designed to limit the extent to which welfare benefits (including post-retirement medical benefits) were prefunded, Congress noted that the minimum standards of the Employee Retirement Income Security Act of 1974 (ERISA) and of the Code relating to employee participation, vesting, accrual, and funding applicable to pension plans do not apply to welfare benefit plans. Congress was concerned that, in the absence of minimum standards, the reasonable expectations of employees and their dependents under welfare benefit plans could be unreasonably disappointed. Congress was also concerned that the imposition of minimum standards could have undesirable results if the standards are unnecessary or improperly designed.

The Deficit Reduction Act of 1984 directed the Secretary of the Treasury to study the possible means of providing minimum standards for employee participation, vesting, accrual, and funding under welfare benefit plans for current and retired employees (including separated employees). The study is to include a review of whether the funding of welfare benefits is adequate, inadequate, or excessive. The Secretary was required to report to Congress with respect to the study by February 1, 1985. The Congress expected that the Secretary will provide suggestions for minimum standards where appropriate.

The Secretary has not yet reported the Department's findings to Congress.

Senator **Heinz**. Ladies and gentlemen, this hearing of the Subcommittee on Savings, Pensions and Investment Policy of the Finance Committee will come to order.

I want to apologize to all for starting an hour late; but the Senate leadership scheduled a meeting with Secretary Shultz at 2 which was previously unanticipated, and as a result we have had to lag our schedule by approximately an hour.

In order to expedite and to try to keep the witnesses who are on at the end of the schedule as much to schedule as possible, I would ask our witnesses to try to keep their statements to the agreed-upon length. I will try to keep my questions short and to the point, and any help I could have in keeping your answers short and to the point would be greatly appreciated by all.

The problem we are here to consider today is one with serious consequences for the income and well-being of retired workers and their families, both now and in the future. Simply stated, the problem is that employers have promised nearly $200 billion in health benefits for workers in retirement which they have not yet begun to fund. Unfunded liabilities of this magnitude are a source of insecurity not only for the retirees who need these benefits but for the employers who must pay for them.

With rising health insurance costs and growing concerns about these liabilities, many employers are searching for ways to either fund these benefits or cut back on their promise of health care coverage.

Congress made matters worse last year by eliminating the tax advantages for VEBA's, voluntary employee benefit associations, which employers had just begun to use to prefund the retiree health benefit.

While the concern that VEBA's were ripe for abuse was legitimate, the shutdown of the VEBA mechanism left employers high and dry in their efforts to fund retiree health liabilities. Worse yet, it left the nine million retirees with benefits and the millions of workers still to come with no hope of making these vital health benefits more secure.

Finding a way to secure post-retirement health benefits must be an integral part of our efforts to bring greater income security to America's elderly. It is my hope that these hearings today will give us a greater understanding of the problem and a clearer sense of the solutions.

Specifically, we would like to hear comments from our witnesses today on whether employers should be permitted to prefund retiree health benefits in a tax-favored fund, and whether Congress should mandate funding as a condition for providing these benefits. We would also like to know what kinds of benefit guarantees for workers and retirees should be attached to any funding vehicle. Finally, we would be interested in hearing the comments of the witnesses on the funding options that we should consider: should we reinstate the VEBA, or come up with something new?

The Senate Special Committee on Aging, which I chair, has recently released an information paper on funding of post-retirement health benefits, and, without objection, I would enter a copy of this paper into the record for this hearing.

[The information paper follows:]

FUNDING POST-RETIREMENT HEALTH BENEFITS

A Report Prepared by the Staff of the
U.S. Senate Special Committee on Aging

July 1985

FUNDING POST-RETIREMENT HEALTH BENEFITS

OVERVIEW

In 1984, the Congress enacted provisions eliminating tax advantages for arrangements employers were beginning to use to pre-fund retiree health benefits. These provisions are scheduled to go into effect in 1986. Before the change takes effect, the Congress needs to review this decision in light of the importance of funding to the continued availability of post-retirement health benefits.

Corporate retiree health benefits have become an important source of supplementation to Medicare coverage for older Americans. More than 5.5 million retired workers and 3.8 million spouses are covered under employer- or union-sponsored health plans. Most of these plans continue coverage until Medicare eligibility begins, for workers who retiree early, and supplement Medicare benefits after age 65. These group plans provide older Americans with protection that would otherwise be too costly for an individual to purchase.

As important as retiree health benefits are, their future is increasingly in doubt. On the one hand, employers are finding the costs and potential liabilities for retiree health unpredictable and potentially devastating. Recent pressure for health care cost containment has forced employers to acknowledge the rapidly growing cost of covering retirees in group health plans. Per-worker costs of covering retirees have risen in older industries with an increase in the ratio of retirees to active workers. In addition, recent reductions in Medicare benefits and cost-shifting by hospitals have increased employers' costs.

Employers facing rising costs for retiree health benefits find themselves, at the same time, with diminished flexibility to manage these costs. They are now required by the Financial Accounting Standards Board (FASB) to disclose information on the cost and funding of retiree benefits on their annual financial statements, and may eventually be required to show unfunded liabilities for these benefits on the corporate balance sheet. At the same time, the Congress acted to discourage employers from funding their retiree health liabilities by limiting the use of Voluntary Employee Benefit Associations (VEBAs) for this purpose in the 1984 Deficit Reduction Act.

Employer flexibility to respond to cost pressures has been further limited by court rulings that have restricted the employer's ability to modify retiree health benefits. In two recent cases, the courts held that employers cannot cancel benefits or raise the cost of coverage for those who have already retired.

Despite the recent move of the courts to protect benefit rights, post-retirement health benefits are still neither secure nor predictable for retirees who must rely on them. Generally, only workers who are entitled to a pension become eligible upon retirement for continued health coverage. Those who change employers frequently or whose last job is not covered never earn a benefit. In addition, when a plant is closed or a company is in financial trouble, workers and retirees may easily lose their group health coverage.

Some contend that VEBAs or some other tax-favored funding vehicle must be available to improve the security of these benefits for workers and help employers prepare adequately for their cost. As with funded pension benefits, individuals could earn a non-forfeitable right to funded health benefits which could be partially guaranteed in the event of business failure or plan termination. Employers could benefit from the tax advantages of a non-taxable trust to build sufficient reserves to meet anticipated health plan costs.

However, pre-funding raises several issues:

- Should pre-funding be provided as an option for employers, or should they be required to pre-fund retiree health benefits if they offer them (as they are with pensions)? Should pre-funding be attached to benefit guarantees for covered workers?

- Should employers be required to pre-fund a package of specified health services or should they fund only a cash benefit?

- Should tax revenues be used to encourage employers to supplement acute coverage, or should limited resources be directed at other vehicles for financing the health needs of the elderly?

Whether the limitations imposed on the use of VEBAs go into effect in January 1986 or not, the problems of employer-provided post-retirement medical benefits will remain unresolved. More creative solutions are needed to both encourage employers to provide retiree health coverage, and to make that coverage more secure for retirees' lives.

WHAT ARE POST-RETIREMENT HEALTH BENEFITS?

MEDICARE IS THE FOUNDATION

Employer- or union-sponsored post-retirement health benefits are group health insurance plans which provide coverage for retirees to supplement Medicare. Medicare is the fundamental health benefit for retirees, covering over 26 million older persons -- almost every American over the age of 65. But Medicare does not by itself meet all of the critical needs of the elderly. The biggest gap in Medicare coverage is that it is not available to retirees younger than age 65. An additional gap is that it focuses, by design, on acute care needs and provides little or no preventive care, long-term care, or catastrophic protection. Even for the acute care it covers, Medicare requires considerable cost-sharing by beneficiaries in the form of a premium, deductibles, and co-payments.

CONTINUED COVERAGE IN GROUP PLANS PROVIDES VALUABLE PROTECTION

Continued coverage in group plans provides an important protection for many elderly from the prohibitive cost of purchasing supplemental coverage individually or paying costs not covered by Medicare out-of-pocket. Group plans now pay roughly 20 percent of the health costs of retirees in the plan.

Many retirees not continued in group plans have the option at retirement of converting the employer policy to an individual policy. Conversion policies are often more expensive than policies sold in the individual market because they are issued without regard to pre-existing conditions and there is no waiting period. Some conversion policies can cost a person age 60-64 as much as $220 a month per person -- about 75 percent of the average early retiree couples Social Security benefit -- compared to $140 a month per person for an individual policy -- about 50 percent of the Social Security benefit.

Out-of-pocket costs are high as well. The average person 65 years of age or older pays $1,660 a year out-of-pocket -- roughly 15 percent of the average annual income for this group.

EMPLOYER PLANS FOR RETIREES SUPPLEMENT MEDICARE

An estimated 9 million retired workers and spouses 45 and over were covered in 1980 under employer- or union-sponsored health plans. Over 5 million of these were not yet eligible for Medicare. Nearly 4 million were age 65 or older - about one out of every six older Americans.

Employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. Many plans then either adjust coverage in the employee health plan or provide a separate plan to take Medicare benefits into consideration.

Most corporations provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. One of two approaches may be used: a "carve-out" or a "Medicare supplement". The "carve-out" continues the retiree in the employees' group plan, but carves out benefits provided by Medicare to avoid duplicate coverage. In a variation on this approach, called "co-ordination of benefits", the plan pays what it would in the absence of Medicare, but the total payment is limited to 100 percent of the expense. Because this type of plan pays for services the plan provides that Medicare does not pay for, its costs are affected by changes in Medicare benefits.

The "Medicare supplement" avoids this problem by specifying exactly the benefits that will be paid by the plan. In addition, the supplement can tailor benefits to the needs of the retiree. While the costs of the supplement can be more easily controlled, this approach requires the design and administration of a separate plan. It also may result in a change in benefits for early retirees at age 65.

WHO IS COVERED BY CORPORATE RETIREE HEALTH PLANS

Continuation of group health coverage after retirement is fairly common among large employers. Data from the 1984 level of benefits survey by the Department of Labor indicates that 60 percent of the participants in health plans offered by employers with 100 or more employees were in plans continuing coverage after early retirement, and 57 percent were in plans continuing coverage after age 65.

Retiree health benefits are more commonly offered by large employers than by small employers. In 1980, 84 percent of the participants in firms with 2500 or more employees were in health plans that continued benefits after early retirement. At the same time only 47 percent of the participants in firms with 100 to 250 employees were in plans continuing benefits.

In most companies, employees become eligible to receive health benefits when they retire from the company. In some cases coverage is limited to retirees who are eligible to receive a pension or who meet specified age and service requirements. Employees who do not meet the requirements for benefits at retirement or who leave the company before retirement usually do not qualify for health benefits.

EMPLOYER CONCERNS

COST

Employers have become increasingly concerned in recent years about the rising cost of company-paid health benefits for retired employees. Currently, the health costs for retirees average $3,000 to $5,000 annually for those under age 65 and $600 to $1,500 for those age 65 and older. Large employers have seen health benefit costs rise in the last fifteen years from less than 2 percent to nearly 5 percent of payroll. Overall health insurance costs have increased and the retiree portion has expanded substantially for many employers for several reasons:

- The cost of medical care has risen rapidly in recent years. Since 1965, health costs have grown at triple the rate of costs for other goods and services. Health care costs for the elderly has grown twice as fast as those for the non-elderly.
- The ratio of retired to active employees has increased for many employers, particularly in older industries or in industries that reduced their active workforce in the early 1980s.
- The trend toward earlier retirement accelerated by early out provisions offered to workers during the recession has increased the proportion of retired workers not covered by Medicare in many plans.
- Recent Medicare changes have begun to shift costs to corporate plans. Retiree costs have particularly been affected by increases in the Part B premium and cost-shifting by hospitals. Other threatened changes, such as the one-month delay in eligibility, would further increase employer costs.

LIABILITY

Employers are increasingly troubled that they are assuming liabilities for health benefits to retirees that they can neither control nor fund. The liabilities result not only from rising costs but also from recent court decisions prohibiting benefit reductions to retirees and accounting standards changes requiring employers to "book" retiree health liabilities.

Court Cases

Recent court cases have reinforced the concept that employers have a legal responsibility to provide promised health benefits to retirees for life once they have retired. While Federal law does not require employers either to provide retiree health benefits or to set aside reserves to fund them if they provide them, Federal law does give participants and beneficiaries the right to sue to recover promised benefits.

A number of court challenges have sought to restore or protect promised health benefits for retirees. These challenges have centered around the duration of the real or implied promise to retirees. Where the promise has been vague, the courts have tended to conclude that the benefits are to be paid for life.

Two recent cases are particularly significant. *Eardman v. Bethlehem Steel Corporation* - Bethlehem Steel instituted cost containment features in a medical plan covering 16,000 non-union retirees. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. Bethlehem appealed and, in a recent settlement, agreed to provide a permanent health program for the retirees combining the features of the original and modified medical plans.

Hansen v. White Farm Equipment Co., - White Farm canceled retiree medical coverage when it filed for Chapter 11 reorganization. A U.S district court reversed a bankruptcy court decision and held that White Farm had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear. White Farm has appealed.

Despite these court decisions indicating a vested right by retirees to benefits, most employers still feel they can amend or terminate post-retirement medical benefits for retirees if they are careful. In a recent survey by the Washington Business Group on Health, more that 80 percent of the large employers surveyed felt they retained the right to modify health benefits for current retirees.

Accounting Standards

Unlike pensions, retiree health benefits do not have to be funded, and generally are not. Most employers now treat the expense as a current operating cost. The Financial Accounting Standards Board (FASB), however, is moving in the direction of requiring employers to recognize and disclose the unfunded liability for future post-employment health benefits.

In November 1984, FASB adopted guidelines requiring corporations to disclose information about post-retirement health and welfare benefits as a footnote on their financial statements. This change alone will force employers to separate and acknowledge the current cost of their retiree health programs.

FASB is still considering requiring employers to report the unfunded liability for their retiree health benefits on their balance sheets. Unfunded liabilities could range from 4 to 50 times the amount that employers are now paying annually for retiree health benefits. Placing these unfunded liabilities on the books could conceivably require a substantial increase in annual employer contributions.

EMPLOYEE CONCERNS

BENEFIT GUARANTEES

While ERISA provides minimum standards and benefit guarantees for workers participating in employer-sponsored pension plans, there are no similar standards or guarantees for health or welfare benefits. In recent years, thousands of retirees have lost employer-sponsored health coverage or had their benefits scaled back either as a result of plant closings or cost-containment measures adopted by employers. While retirees have the right to sue to recover promised benefits, employer-sponsored plans often are careful to avoid language which might guarantee health benefits to retirees for life.

Retiree health benefits also differ from pension benefits in that workers cannot earn the right to partial benefits during their working career. Instead, retiree health benefits are usually vested only upon retirement and are often provided by the last employer to all retirees without regard to length of service. As a result, workers cannot accumulate retiree health benefits and must be dependent on a single employer to meet their health needs.

Pre-funding retiree health benefits is directly tied to the question of benefit guarantees. If employers set aside funds to meet the costs of these benefits, the chances are increased that benefits will be provided to workers in the event of cost-containment or plant closings. In addition, the accumulation of funds in advance improve the chances that employers can provide mobile workers with the cash equivalent of partial benefits.

FUNDING

FUNDING METHODS

Employers who provide health coverage for their retirees have three options for paying for these benefits:

Pay-as-you-go: Most companies pay for the annual expenses of the group health plan as they occur. Retirees are included with active employees in the group health plan. The company makes the medical claims payments each year, plus funds a small reserve for unanticipated costs.

Terminal Funding: The company incurs the full cost of anticipated medical claims for the remaining life of the retiree in a single payment at retirement. Terminal funding costs more initially, but is less expensive over the long run. Retired employees have greater security under this method because the benefit is fully paid for at retirement and not dependent on the future profitability of the company.

Level Actuarial Cost Methods: The company budgets for the cost of retirement health benefits on a level basis over the working life of the employee; in much the same way as the company is required to fund pension benefits. This method has the highest initial cost, but the lowest cost over the long term. It also provides the greatest degree of security to employees since funds are set aside before retirement.

Currently, employers overwhelmingly pay for retiree health benefits as a current operating expense. At least, only 5 percent of employers appear to be using some method to pre-fund these benefits. However, rising costs combined with the growing pressure from the courts and FASB to recognize and meet these costs is causing many employers to search for ways to pre-fund retiree health benefits.

AVAILABLE FUNDING VEHICLES

Immediately prior to the enactment of the Deficit Reduction Act (DEFRA) in 1984, employers were beginning to show an interest in pre-funding retiree health benefits. Two alternative vehicles for employers to use in self-funding post-retirement health benefits have generally been available: Voluntary Employee Benefit Associations (VEBAs) and Section 401(h) plans. However, in the Deficit Reduction Act of 1984 (DEFRA), the Congress greatly limited the tax advantages associated with the most popular vehicle -- the VEBA -- to prevent its widespread use. The remaining option -- the 401(h) plan -- has had little use in the past.

VEBAs

A VEBA is a separate organization established for the benefit of employees to provide them with any of a number of specified employee benefits - including health and life insurance for retirees. VEBAs may not be used to fund pension benefits. The organization is exempt from taxation under Section 501(c)(9) of the Internal Revenue Code (IRC). In addition, employer contributions to a VEBA are deductible, and certain benefits are excluded from the income of beneficiaries.

Congress acted in DEFRA to limit the tax advantages associated with the use of a VEBA for retiree medical plans, effective January 1, 1986, on the grounds that there was too much potential for abuse as a corporate tax shelter. Specifically, DEFRA limited the maximum amount of contributions an employer can deduct to the current expenses for the plan plus a reserve of 35 percent of current expenses. Reserves in excess of this amount or attributable to pre-funding are taxed as unrelated business income to the employer. In addition, any reversion of assets to the benefit of the employer are subject to a 100 percent excise tax.

The DEFRA changes are effectively discouraging employers from using VEBAs to pre-fund retiree health benefits. The trusts can no longer benefit from tax-free growth since investment earnings on the trust are taxable income. In addition, employers are discouraged from pre-funding because they can only deduct current costs and are taxed 100 on assets above the amount needed to pay benefits.

401(h) Plans

Under IRC Section 401(h), tax qualified plans which provide pension and annuity benefits may also provide certain medical benefits to retired employees and their spouses. The benefits must be subordinate to the retirement benefits provided by the plan and must be maintained in a separate account. Employer contributions have to be reasonable and amounts in excess of the amount needed cannot be diverted to other purposes and can be returned to an employer only after all liabilities are satisfied.

Relatively few employers have taken advantage of this provision in the past. Reasons usually cited for the lack of use of 401(h) are that they leave the employer to small a margin of error in anticipating and funding for the cost of the health plan. Health benefits funded through 401(h):

- must relate to the pension benefits and cannot receive more than 25 percent of the total contributions;
- must be segregated from the pension funds and excess reserves cannot be used to offset other costs in the pension plan;

FUNDING ISSUES AND OPTIONS

Some have proposed that the availability of a tax-favored funding mechanism for retiree health benefits would be a means for both improving the security of these benefits for workers and helping employers prepare adequately for their cost. There are three issues to be raised about such a funding vehicle. First, should employers be permitted to voluntarily pre-fund retiree health benefits or should they be required to fund them if they provide them? Second, what kind of benefits should be funded -- specified services or cash benefits? Third, should tax revenues even be used to encourage employers-sponsored supplementation or should they be used to encourage coverage of currently uncovered health expenses?

Mandatory or Voluntary Funding?

ERISA requires that if pensions are provided, they must be adequately funded, employees must be able to gain a non-forfeitable right to receive them, and benefits must be distributed in the event the plan is terminated. A mandatory funding requirement for retiree health -- so-called "ERISA-fication" -- would require if retiree health benefits were provided at all that they meet standards similar to those governing pensions. Voluntary funding, by contrast, would permit employers to pre-fund retiree health benefits and meet ERISA-like standards, but would also allow employers to continue to fund these benefits on a pay-as-you-go basis.

Mandatory funding would do the most to secure employees' rights to retiree health benefits. Companies that failed or terminated a retiree health plan would have to provide some benefits to current retirees and vested workers. Some have even suggested retiree health benefits could be guaranteed by an insurance program similar to that which now protects some pension benefits.

The disadvantage of mandatory funding is that it might set the stakes for operating a retiree health program too high and discourage employers from providing these benefits. Long-term costs are much more difficult to predict for health benefits than they are for pensions. "ERISA-fication" might legally bind employers to meet costs that become intolerable in the future. At least some employers have been willing to provide these benefits because they believe they have the latitude to alter them or terminate them in the future if necessary. Employers who chose to provide retiree health in the wake of "ERISA-fication" would most likely fund a limited cash benefit they could control rather than a particular health package for their employees.

Voluntary funding would be a "carrot and stick" approach to protecting employees' rights. Those employers who wanted the accounting and tax advantages of pre-funding health benefits would have to provide benefit guarantees for workers and retirees. While this approach would permit employers to continue to operate unfunded and non-guaranteed plans, there would be an incentive to fund and guarantee the benefits. While voluntary funding would not protect workers in plans as effectively, it would do less to discourage employers from providing these benefits in the first place. However, it would set a dangerous precedent under ERISA for permitting employers to operate non-sanctioned, non-tax-qualified plans.

What Kind of Benefits?

Traditionally retiree health plans have provided a defined package of health services the plan would pay for without regard to cost. However, with the cost of health services rising rapidly and long-term costs unpredictable, there is growing interest in covering workers for a specified cash benefit instead, which would be used to purchase of health insurance.

The traditional coverage for services has been advantageous to retirees. Regardless of what the increase in health costs, they have been covered for a specified level of health care. This approach, however, has severe limitations for employers who might want to pre-fund health benefits. First, the cost of guaranting services in the long run is too open-ended for employers. Not only is it difficult to anticipate, and thus adequately fund, these future costs, but many employers will be unwilling to be legally obligated to meet these costs in the distant future. Second, with major technological changes in health care in the offing, it is hard to define and guarantee specific health benefits that would meet retiree needs decades hence. Third, it will be difficult for employees covered under traditional plans to earn vested and portable rights to a single package of health services if they work for a number of employers.

The alternative is to fund and guarantee a cash benefit which retirees can use to purchase health coverage in the group plan. This approach protects the employer from unanticipated cost increases, but leaves workers fully exposed for the risk of rising health costs. If employers are required to pre-fund retiree health benefits, it is likely that many will turn to cash benefits to limit their liability. Mobile workers could more easily transport and accumulate portions of benefits from multiple employers. Cash health benefits, however, would be resemble pensions. It can be argued that employees would be better off if instead of being locked-in to a specified health payment, employers simply increased their pension benefits and let them allocate the income they want to health coverage.

Should Tax Benefits be Used for Pre-funding?

Concern about funding employer-sponsored retiree health benefits is focused on the only one part of the health problem for older Americans -- payment for acute care services. Development of an adequate mechanism to fund acute care does little to address the most serious future health financing issue -- payment for long-term care. Employers and aging advocates express fears that adequately funding employer-sponsored retiree health benefits will permit the Congress to respond to Medicare financing problems by reducing benefits and shifting the cost for acute care increasingly to employers and the private sector. At the same time, pre-funding acute care costs will consume limited tax revenues that might otherwise have been available to finance some limited efforts to protect retirees and their families from the risk of the catastrophic costs of long-term care.

Senator HEINZ. I may say that I am pleased that Mr. Ross of the Treasury Department could be here this afternoon. The Treasury and Department of Labor have been hard at work on a study of the funding needs of retiree health plans and the means for providing minimum standards for employee participation, vesting, and the funding of these benefits.

Mr. Ross, I know you are not going to be able to provide us with the results of your study yet; but I am glad you can be here, in any event, to give us Treasury's views on these issues.

So, without further ado, I would like Mr. Ross to come forward to take his seat at the witness table.

Mr. Ross.

STATEMENT OF DENNIS ROSS, DEPUTY TAX LEGISLATIVE COUNSEL, DEPARTMENT OF TREASURY, WASHINGTON, DC

Mr. ROSS. Thank you, Mr. Chairman.

I am pleased to appear before you today to discuss the Treasury Department's views on the appropriate tax treatment of employer-maintained plans to provide retired employees with health benefits. In the context of that discussion I wish also to report on the present status of the study to which you have just referred, mandated in the Tax Reform Act of 1984, of the various tax and benefit issues relating to post-retirement health benefits.

I would like to begin my testimony with a brief description of the tax principles applicable to plans to provide active and retired employees with health benefits. With that as background, I wish to dicuss in general terms the changes enacted in the 1984 legislation, together with some of the issues that remain to be addressed concerning prefunded post-retirement health benefits.

The tax law, as you know, generally requires an employee to include all compensation in income, including wages, commissions, property, and other in-kind benefits. Compensation paid in the form of certain in-kind benefits, however, may be excluded from gross income if provided under qualifying employer-maintained plans, including profit sharing, pension, and health plans.

On the employer's side, a deduction is permitted for employee compensation, including amounts paid with respect to an employee health plan. As a general matter, the year in which an employer is permitted to deduct compensation, whether paid as cash or in-kind benefits, corresponds to the year in which the employees include the compensation in income. Moreover, if an employer prefunds future compensation by establishing a reserve, income on the amount set aside in the reserve is taxable to the employer.

As you know, employers receive more favorable tax treatment for future compensation provided through profit sharing and pension plans that comply with various qualification rules, including nondiscrimination rules and minimum standards relating to participation, vesting, benefit accrual and funding. In such cases, the employer receives a current deduction for reserve contributions, and the reserve is permitted to grow on a tax-exempt basis.

Now, prior to the 1984 act, favorable tax treatment was also available for compensatory health benefits provided through welfare benefit funds, including voluntary employees' beneficiary associations commonly known as VEBA's. Such funds were not, however, required to satisfy the minimum standards applicable to qualified retirement plans.

The 1984 act adopted rules that, with limited exceptions for post-retirement life and health benefits, subject an employer using a welfare benefit fund such as a VEBA to the general tax principles applicable to compensation benefits outside of the area of qualified pension and profit sharing plans; that is, no current deduction for contributions to provide future benefits, and no tax-free accumulation of reserves.

Congress thus sought to limit the extent to which employers, by virtue of favorable tax treatment for welfare benefit funds, could shift to the Federal Government the cost of providing such benefits.

In the case of post-retirement health benefits, the 1984 act allowed employers to continue to deduct reserve contributions but provided that reserve funds set aside for post-retirement health benefits would grow on a taxable rather than tax-exempt basis.

The 1984 act changes reflected a concern that tax advantages not be provided for prefunded welfare benefits unless the promised benefits were specifically defined and the employers' liability for the benefits legally fixed. In this regard, Congress directed the Treasury Department to study the funding of Welfare benefit plans and the need for minimum participation, benefit accrual, vesting, and funding standards similar to those applicable to qualified retirement plans. Our study, which we have undertaken in conjunction with the Department of Labor, has not been completed.

Although we are, thus, unprepared to offer specific recommendations or conclusions, I would like to discuss in general terms the tax and health policy issues on which we have focused.

A necessary threshold issue for our study is whether the existing structure of public and private retirement security programs is adequate, both in regard to the aggregate benefits provided and to the mix between cash and in-kind benefits. Although we have not concluded our analysis, any argument for additional public support in this area must be examined in light of the existing constraints on the Federal budget. In the same vein, the creation of new or expanded tax incentives would contradict current efforts to reform the tax system.

The administration's tax-reform proposals would expand the base of taxable income in order to make the tax system fairer and to reduce marginal tax rates. Although those proposals would retain basic incentives for retirement savings, the purposes of tax reform would be undermined by the extension of similar incentives to post-retirement health benefits.

A related issue is whether existing plans for postretirement health benefits are adequately funded. Very few employers were prefunding postretirement health benefits before the 1984 act, and very few are doing so today. Many employers view postretirement health benefits as discretionary and believe they retain the right to reduce or terminate such benefits for both retired and active employees.

Employers may well fear that prefunding would restrict their ability to reduce or eliminate currently envisioned postretirement health benefits, not merely for current retirees, as some courts have already held, but also for future retirees.

In any case, recent estimates of the Department of Labor indicate that the present value of employers' unfunded liability for currently envisioned postretirement health benefits is well in excess of $100 billion.

Our study has also considered how prefunded postretirement health benefit plans should be structured. For example, under a defined-contribution approach the employer would contribute amounts to individual accounts. After retirement, the amounts accumulated in an individual's account would be used to provide health benefits. Alternatively, under a defined-health-benefit approach the employer would prefund amounts sufficient to provide retirees with a specific type and level of health coverage. And finally, under a defined-dollar-benefit approach, the employer would prefund amounts sufficient to provide retirees with a specified annual dollar benefit that would be used to provide health coverage.

Each of these approaches to the prefunding of post-retirement health benefits raises significant issues. Under both the defined contribution and the defined dollar benefit approaches, there may not be sufficient funds accumulated for an employee to maintain his or her preretirement type and level of health benefits. At the same time, the defined contribution and dollar benefit approaches permit an employer to control its costs by modifying the type and level of health coverage provided to retirees. Furthermore, these approaches could be developed as modifications of existing defined benefit or money purchase pension plans. In effect, some portion of a retiree's annual contribution under a money purchase pension plan would be dedicated to the provision of retiree health coverage.

Under the defined health benefit approach, it would be necessary to project the future cost of promised health benefits in order to calculate the appropriate levels of prefunding. Such projection is difficult because of the need to consider medical care inflation, increases and decreases in medical utilization, and cost shifting for Medicare. Moreover, absent regular accrual and vesting of benefits, actuarial assumptions have a dramatic impact on the reliability of future cost predictions. For example, if an employee accrues and vests in the full postretirement health benefit only by attaining age 55 and completing 10 years of service, the preretirement turnover assumption becomes a critically important variable.

The defined health benefit approach also makes cost control more difficult, because of the employer's commitment to a certain type and level of health benefits; thus, it would presumably be necessary to restrict the employer's ability to reduce or eliminate promised health benefits even though changes in medical utilization or practice could make such reductions appropriate cost-containment measures.

Although I should again state that our analysis in this area is incomplete, we currently are most interested in the defined dollar approach. This approach would eliminate much of the uncertainty associated with projecting future medical costs and would not restrict modifications in the type and level of health benefits to adjust for changes in medical utilization and practice.

In addition, because it promises a benefit measured in dollars, the defined dollar benefit approach would facilitate partial vesting of benefits over an employee's term of service.

We are also studying whether minimum participation, benefit accrual, vesting, and funding standards are necessary if favorable treatment is provided for postretirement health benefits. The appropriate frame of reference for this issue is, of course, the participation, accrual, vesting, and funding standards imposed by ERISA on qualified retirement plans.

The basic premises of ERISA are that an employer's pension promise must be specifically defined and adequately funded, and employees must accrue and vest in pension benefits in accordance with reasonable minimum standards.

We believe the basic logic of ERISA should apply, to the extent tax advantages as provided for postretirement health benefits. Although I should reiterate our concern about the creation of new tax incentives, any such incentives must be conditioned on the employer's legal liability for specifically defined benefits.

As I suggested earlier, it appears to us that a defined dollar benefit approach fits more readily with ERISA type standards for accrual and vesting, and would avoid the conflict between cost control modifications and the employer's commitment to a specific type and level of coverage. In this respect, the design of appropriate minimum standards requires that we first decide upon the exact nature and form of the benefit promise to which employees accrue rights.

In closing, I would like to reaffirm that the Treasury Department is pleased to play a role in the study of postretirement health benefits. The questions raised in this area involve fundamental issues of retirement and health policy and should properly be subject to examination on a regular basis.

Although significant work remains to be done, we have received useful input from many parties, including employer and employee representatives, representatives of insurance companies and consulting companies, as well as health economists and other experts. We welcome this aid, and we well as well, the assistance and cooperation of the Department of Labor.

I would be pleased to respond to any of your questions, Mr. Chairman.

[Mr. Ross's written testimony follows:]

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STATEMENT OF
DENNIS E. ROSS
DEPUTY TAX LEGISLATIVE COUNSEL
DEPARTMENT OF THE TREASURY
BEFORE THE SUBCOMMITTEE ON SAVINGS,
PENSIONS, AND INVESTMENT POLICY
OF THE SENATE COMMITTEE ON FINANCE

Mr. Chairman and Members of the Subcommittee:

I am pleased to appear before you today to discuss the Treasury Department's views on the appropriate tax treatment of employer-maintained plans to provide retired employees with health benefits. In the context of that discussion, I wish also to report on the present status of the study, mandated in the Tax Reform Act of 1984 (the "1984 Act"), of the various tax and benefit issues relating to post-retirement health benefits.

I would like to begin my testimony with a description of the tax principles applicable to plans to provide active and retired employees with health benefits. With that as background, I wish to discuss the changes enacted in the 1984 Act, together with some of the issues that remain to be addressed concerning prefunded post-retirement health benefits.

General Tax Principles

The tax law generally requires an employee to include in income all compensation received during the year for services performed for the employer, including wages, commissions, property, and other in-kind benefits. Compensation paid in the form of certain in-kind benefits, however, may be excluded from gross income if provided under qualifying employer-maintained plans, including profit-sharing, pension, and health plans.

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On the employer's side, a deduction is permitted for ordinary and necessary business expenses paid or incurred during a taxable year, including a reasonable allowance for employee compensation. "Compensation" includes ordinary and necessary amounts paid with respect to a health plan. As a general matter, the year in which an employer is permitted to deduct compensation, whether as cash or in-kind benefits, corresponds to the year in which the employees include (or, but for an exclusion, would include) the compensation in income. Moreover, if an employer prefunds future compensation by establishing a reserve, income on the reserve is taxable to the employer.

In certain circumstances, an employer may be eligible for more favorable treatment for reserves for future compensation and benefits. In such cases, the employer is allowed a current deduction for contributions to a reserve to prefund future compensation or benefits, and the reserve is permitted to grow on a tax-exempt basis. With respect to cash compensation, favorable treatment generally is available only with respect to profit-sharing and pension plans that comply with various qualification rules, including nondiscrimination rules and minimum standards relating to participation, vesting, benefit accrual, and funding.

Prior to the 1984 Act, favorable tax treatment was also available for compensatory health benefits provided through welfare benefit funds, including voluntary employees' beneficiary associations ("VEBAs") and certain arrangements maintained by insurance companies for the benefit of employers (i.e., retired lives reserves). Although the favorable tax treatment of such funds was the same as that available to qualified retirement plans, welfare benefit funds were not required to satisfy the minimum standards applicable to qualified plans. (See the following section for a discussion of the 1984 Act as it relates to post-retirement health benefits.)

Although the tax treatment of welfare benefit funds was changed in the 1984 Act, employers remain able to prefund post-retirement health benefits on a tax-favored basis through contributions to a separate reserve account maintained in conjunction with a qualified pension or annuity plan. (Section 401(h) of the Code.) Generally, such health benefits, when added to any life insurance provided under the pension or annuity plan, must be subordinate to the retirement benefits provided under the plan. This means that the contributions made to the plan to provide health benefits and life insurance may not exceed 25 percent of the total contributions to the plan (other than contributions to provide past service credits). Amounts set aside in a separate account to provide post-retirement medical benefits may not revert to the employer or be used for any other purpose before the satisfaction of all liabilities to provide health benefits. Finally, the health plan must satisfy certain nondiscrimination rules.

The Tax Reform Act of 1984

The 1984 Act adopted rules that, with limited exceptions for post-retirement life and health benefits, subject an employer using a welfare benefit fund, such as a VEBA, to the general tax principles applicable to compensation and benefits outside of the area of qualified pension and profit-sharing plans: no current deduction for contributions to provide future benefits and no tax-free accumulation of reserves. Congress thus sought to limit the extent to which employers, by virtue of the favorable tax treatment for welfare benefit funds, could shift the cost of the benefits to the Federal government.

In the case of post-retirement health benefits, the 1984 Act provides that an employer may deduct contributions to accumulate, no more rapidly than over its employees' years of service, an actuarially justified reserve to provide retired employees with health benefits. In calculating the actuarial reserve for post-retirement health benefits, the rules prohibit consideration of projected increases in the current cost and level of such benefits provided to retirees. In addition, the funds set aside for post-retirement health benefits are not permitted to grow on a tax-exempt basis; rather, the income of these funds is subject to the unrelated business income tax. In effect, an employer is permitted a deduction for contributions to a taxable, rather than a tax-exempt, trust to prefund post-retirement health benefits.

Many have characterized the 1984 Act limits on tax-favored prefunding as merely "anti-abuse" rules, concerned with preventing such situations as a corporation excessively overfunding a VEBA or using a VEBA primarily for the benefit of its key employees. Although the 1984 Act did adopt rules directed at the "abusive" use of VEBAs and other funds, the new rules attempt more broadly to conform the tax treatment of employers maintaining welfare benefit funds to the actual economic cost of the benefits provided. In this respect, the limits on tax-favored prefunding are consistent with the various provisions in the 1984 Act that apply "time value of money" concepts to the amount and timing of income and deductions. Indeed, the welfare benefit rules are very similar to the rules that permit limited employer deductions for contributions to taxable reserves for future nuclear power decomissioning and mine reclamation expenses.

An additional concern reflected in the 1984 Act is that tax advantages not be provided for prefunded welfare benefits unless the promised benefits are specifically defined and the employer's liability for the benefits is legally fixed. Because post-retirement health benefits generally are not subject to statutory accrual or vesting provisions, it is not possible to fix the future benefits to which employees have accrued rights or the future liability for which the employer should be permitted to prefund.

Study of Post-Retirement Health Benefits

Congress' concern that tax advantages not be permitted for prefunded post-retirement health benefits absent proper accrual, vesting, and similar rules was additionally reflected in its request that the Treasury Department study the funding of welfare benefit plans and the need for minimum participation, benefit accrual, vesting, and funding standards similar to those applicable to qualified retirement plans. Our study, which we have undertaken with the Department of Labor, has not been completed. Although we are thus unprepared to offer specific recommendations or conclusions, I would like to discuss in general terms the tax and health policy issues on which we have focused.

Adequacy of Funding and Benefits. A necessary threshold issue for our study is whether the existing structure of public and private retirement security programs is adequate, in regard to both the aggregate benefits and the mix between cash and in-kind benefits. Although we have not concluded our analysis, any argument for additional public support in this area must be examined in light of the existing constraints on the Federal budget. In the same vein, the creation of new or expanded tax incentives would contradict current efforts to reform the tax system. The Administration's tax reform proposals would expand the base of taxable income in order to make the tax system fairer and reduce marginal tax rates. Although the proposals would retain basic incentives for retirement savings, the purposes of tax reform would be undermined by the extension of similar incentives to post-retirement health benefits.

A related issue is whether existing plans for post-retirement health benefits are adequately funded. Very few employers were prefunding post-retirement health benefits before the 1984 Act and very few are currently prefunding such benefits, even though limited tax-favored prefunding continues to be possible under a qualified pension plan. Many employers view post-retirement health benefits as discretionary, and believe they retain the right to reduce or terminate post-retirement health benefits for both retired and active employees. Employers may fear that prefunding would restrict their ability to reduce or eliminate currently envisioned post-retirement health benefits, not merely for current retirees (as some courts have already held), but also for future retirees. In any case, recent estimates of the

Department of Labor indicate that the present value of employers' unfunded liability for currently envisioned post-retirement health benefits is well in excess of $100 billion.

Structure of Benefit Plans. Our study has also considered how prefunded post-retirement health benefit plans should be structured. For example, under a defined contribution approach, the employer would contribute amounts to individual accounts maintained to provide post-retirement health benefits. After retirement, the amounts accumulated in an individual's account would be used to provide health benefits. Under a defined health benefit approach, the employer would prefund amounts sufficient to provide retirees with a specified type and level of health coverage. Under a defined dollar benefit approach, the employer would prefund amounts sufficient to provide retirees with a specified annual dollar benefit that would be used to provide health coverage; this approach would be substantially equivalent to the existing defined benefit retirement plan system under which retired employees generally receive specified annual dollar amounts.

Each of these approaches to the prefunding of post-retirement health benefits raises significant issues. Under both the defined contribution and the defined dollar benefit approaches, there may not be sufficient funds accumulated for an employee to maintain his preretirement type and level of health benefits. At the same time, the defined contributions and dollar benefit approaches permit an employer to control its costs by modifying the type and level of health coverage provided to retirees. Furthermore, these approach could be developed as modifications of existing defined benefit or money purchase pension plans; in effect, some portion of a retiree's annual benefit under a defined benefit retirement plan or contribution under a money purchase pension plan would be dedicated to the provision of retiree health coverage.

Under the defined health benefit approach, it would be necessary to project the future cost of the promised health benefits in order to calculate the appropriate levels of prefunding. Such projection is difficult because of the need to consider medical care inflation, increases and decreases in medical utilization, and cost shifting from Medicare. Moreover, absent regular accrual and vesting of benefits, actuarial assumptions have a dramatic impact on the reliability of future cost predictions. For example, if an employee accrues and vests-in the full post-retirement health benefit only by attaining age 55 and completing ten years of service, the preretirement turnover assumption becomes an important variable.

The defined health benefit approach also makes cost control more difficult because of the employer's commitment to a certain type and level of health benefits. Thus, it would presumably be necessary to restrict an employer's ability to reduce or eliminate promised health benefits, even though changes in medical utilization or practice could make such reductions appropriate cost containment measures.

Although I should again state that our analysis in this area is incomplete, we currently are most interested in the defined dollar benefit approach. This approach would eliminate much of the uncertainty associated with projecting future medical costs and would not restrict modifications in the type and level of health benefits to adjust for changes in medical utilization and practices. In addition, because it promises a benefit measured in dollars, the defined dollar benefit approach would facilitate partial vesting and the portability of benefits.

The defined dollar benefit approach also raises the question of whether existing defined benefit pension plans can or should be modified to permit the payment of a portion of a retiree's annual dollar benefit in the form of health coverage. Separate funding for post-retirement health benefits may not be appropriate if they are regarded as simply another form of post-retirement deferred compensation. Such use of retirement savings to fund health benefits, however, could adversely affect retirees who are not receiving significant annual dollar benefits. Although health benefits cost the same dollar amount for each retiree, pension benefits are wage-related. It thus may be inappropriate to convert a significant portion of a retiree's annual benefit from cash into health coverage.

It will also be important to consider whether, under the defined dollar benefit approach, existing funds that have been set aside to provide pension benefits should be available to provide post-retirement health benefits. Indeed, some have argued that permitting an employer to use excess pension funds to provide post-retirement health benefits would both resolve some of the policy concerns that have recently been raised about asset reversions from defined benefit plans and, at the same time, enable an employer to reduce its unfunded post-retirement health liability.

Minimum Standards. We are also studying whether minimum participation, benefit accrual, vesting, and funding standards are necessary if favorable treatment is provided for post-retirement health benefits. The necessary frame of reference for this issue is, of course, the participation, accrual, vesting, and funding standards imposed by the Employee Retirement Income Security Act of 1974 ("ERISA") on employer-maintained retirement plans. The basic premises of ERISA are that an employer's pension promise must be specifically defined and adequately funded, and employees must accrue and vest in pension benefits in accordance with reasonable minimum standards. If any of these elements is not satisfied, ERISA effectively provides that an employer may not make the pension promise.

Although we believe the basic logic of ERISA would properly apply to the extent tax advantages are provided for post-retirement health benefits, certain of the ERISA requirements may not be readily transferable to the area of health benefits. In particular, if the promised health benefit is a type or level of health coverage, should employees accrue rights to post-retirement health benefits over a specified number of years or merely in a single year (e.g., the year of retirement)? Should graded or cliff vesting schedules be permitted, and in either case what is the slowest vesting schedule that an employer may adopt? Finally, to what extent should an employer be permitted (or required) to modify the nature of the health coverage provided under the plan, e.g., to control costs or take into account changes in medical utilization or practice?

As discussed above, it appears to us that a defined dollar benefit approach fits more readily with ERISA-type standards for accrual and vesting, and would avoid the conflict between cost control modifications and the employer's commitment to a specific type and level of coverage. The design of appropriate minimum standards thus requires that we first define the exact nature and form of the benefit promise to which employees accrue rights.

Conclusion

In closing, I would like to reaffirm that the Treasury Department is pleased to play a role in the study of post-retirement health benefits. The questions raised in this area involve fundamental issues of retirement and health policy, and should properly be subject to examination on a regular basis. Although significant work remains to be done, we have received useful input from many parties, including employer and employee representatives, representatives of insurance companies and consulting companies, and health economists and other experts. We welcome this aid, as well as the assistance and and cooperation of the Department of Labor.

General Information Relating to Post-Retirement Health Benefits

1. Most employers have not yet focused on the question of post-retirement health benefits. Less than one-half of the large employers have analyzed the long-term financial impact of their post-retirement health plans. Most of those that have not plan to do so in the near future. Recent growing interest in post-retirement health benefits may be attributed to an increasing retiree population, rising health care costs for the elderly, increasing recognition of the employers' potential liability, and potential changes in the accounting rules.

2. Most retirees are not covered under employer-maintained health plans. In 1983, about 30 percent of all retirees 65 years and older was covered in such health plans.

3. Most large employers permit retiring employees to continue coverage under their health plans for active employees. In some cases, however, coverage terminates at age 65, when Medicare coverage commences. Larger companies are more likely to provide post-retirement health benefits than are smaller companies. Post-retirement dental coverage is much less prevalent than post-retirement health coverage, and post-retirement vision care is rare.

4. Employers that provide post-retirement health benefits after age 65 generally continue the same coverage provided to active employees until the retiree becomes eligible for Medicare, and thereafter the employer will carve-out Medicare benefits or provide supplemental coverage for health expenses not reimbursed by Medicare. Under a "carve-out" approach, the employer-provided benefit is the health benefit provided to active employees less the amount actually reimbursed by Medicare. Under the Medicare supplement approach, the employer's plan provides health coverage (with their own deductibles and coinsurance) for expenses not covered by Medicare. Some employer plans pay the Medicare Part B premium for the retiree.

5. Post-retirement health plans cover the retiree's spouse and dependent children, generally until the spouse's death or remarriage and the attainment of a specified age by the dependent children.

6. About one-half of the post-retirement health plans are contributory. Between 10 and 15 percent of such plans require an employee contribution of more than 50 percent of the cost of the coverage.

7. Eligibility for post-retirement health benefits is typically tied to the retirement requirements of the employer's pension plan. Generally, these are the completion of (i) ten years of service and the attainment of age 55 or 60, or (ii) the attainment of age 65.

8. Virtually no employers prefund post-retirement health benefits. Surveys generally indicate that fewer than 5 percent of the respondents prefund post-retirement health benefits. Some of those that do prefund such benefits do so on a "termination funding" basis. Most employers provide post-retirement health benefits on a pay-as-you basis. This is the case even though prefunding was possible through VEBAs since about 1970 and continues to be possible under a qualified pension or annuity plan.

9. Most employers that provide post-retirement health benefits do not believe that they are legally obliged to continue such benefits for either current or future retirees. In several recent cases, however, particularly those involving union negotiated plans, courts have decided that employers do not have the unlimited right to reduce or terminate promised health benefits to current retirees. Indeed, in one case, the court concluded that an employer could not terminate promised health benefits for current retirees, even though the employer had reserved the right to terminate such benefits, because such benefits effectively vested upon retirement.

Senator **Heinz**. Mr. Ross. Thank you.

Before I ask any questions, I just want to recognize Senator Mitchell for any opening statement he may care to make.

Senator **Mitchell**. Thank you, Mr. Chairman.

I commend you for holding this hearing to explore some of the issues involved with employer-provided health care benefits to retirees. I do have an opening statement, but in the interest of time I ask that it be inserted in the record at the appropriate point, and defer to your questioning of Mr. Ross.

Senator **Mitchell**. Without objection, so ordered.

Mr. Ross, can you summarize for us your major concerns about the tax treatment of prefunded VEBA's before DEFRA was enacted?

Mr. Ross. Well, before DEFRA the tax advantages for VEBA's were, as I suggested and is really further developed in our written statement, very comparable to the tax advantages provided for qualified retirement plans. That is a considerable tax advantage. The effect of it is to shift a part of the cost of providing the benefits to the Federal Government, in effect, to taxpayers.

As you know, in the context of qualified retirement plans that advantage comes with a number of conditions—the qualification requirements, in particular. Those conditions, at least generally, were not applicable to VEBA's.

Senator **Heinz**. So you are saying your main concern was the lack of minimum standards?

Mr. Ross. Well, I shouldn't say that was the only concern; certainly that was an important concern. One also has to ask——

Senator **Heinz**. What others?

Mr. Ross. Well, one has to ask whether the revenue expense of providing tax advantages to postretirement health plans is one that we are willing to incur. And we certainly have concerns on that grounds as well.

Senator **Heinz**. Could you elaborate on your concerns there?

Mr. Ross. It is the concern that faces government generally: On what purposes it wishes to spend its money, and how much money it has to spend. The creation of tax incentives or expansion of existing tax incentives for postretirement health benefits is a revenue expense, and it is simply a question of whether this is an appropriate use of government revenues.

Senator **Heinz**. Well, let us go into that a little bit more. As I understand that concern, that applies whether or not there would be minimum benefits. Obviously, it is probably an even larger concern if there are no minimum benefits.

Mr. Ross. Certainly.

Senator **Heinz**. But leaving apart that issue, how is providing for regular pension benefits, as we do under ERISA, in an effort to do things that Social Security cannot do different from providing a similar health benefit of some kind—to do the things that Medicare certainly cannot do. An awful low of them that it doesn't do.

Mr. Ross. Mr. Chairman, I don't think there really is a difference in principle. In fact, one of the points I think we are studying and, to the extent we have tentative conclusions, one of the points on which we have at least an observation to offer is that the appropriate treatment of postretirement health benefits is very much

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wrapped up with general retirement policy. And I think you are right to suggest: Why is it different to talk about postretirement health benefits as opposed to pension benefits? And one could in fact say that they aren't really separate, and that the funding for each sort of benefit indeed might come from the same sources. But I don't think that should distract us from the issue of revenue, the extent to which we can afford to spend more money for this purpose.

In sum though, I would agree with you: I don't think there is necessarily a difference in principle.

Senator HEINZ. I am tempted to ask you: How much can we afford to spend on rate cuts as opposed to retirement benefits? But that wouldn't be fair. You can ask it later, George, if you would like.

Going back, though, to the revenue-loss issue, which you are more concerned about—from the employer contribution or from the tax-free buildup?

Mr. ROSS. Well, current law allows a deduction for the employer's contribution, and the critical change made in the 1984 legislation was to deny the tax-free buildup. So in that sense, I would say our concern would be focused on the tax-free buildup.

Senator HEINZ. If the Congress were to enact a prefunding vehicle, what concerns about the tax treatment would you have? And what revenue consequences should we be aware of?

Mr. ROSS. We have not done a revenue estimate, so I couldn't put any number on revenue concerns. I am not sure if you mean by your question to go beyond really the basic question of what sort of dollars are we talking about.

Senator HEINZ. Well, that was the second part of my question, trying to get at what kinds of dollars we are talking about. Is this hundreds of millions per year? Is it billions? Is it tens of billions? What is it?

Mr. ROSS. That is one of the conclusions we have not yet reached. It is something that we will devote attention to.

Senator HEINZ. It will reserve the balance of my questions and recognize Senator Mitchell.

Senator MITCHELL. Mr. Ross, in your testimony you state that the study has not been completed, and therefore you are unprepared to offer specific recommendations. To the extent you can discuss that, from what you have learned so far, in your judgment is there a need for legislation in this area, either to protect retirees or alter the tax treatment for employer costs?

Mr. ROSS. Those are sort of bottom-line conclusions; so, I ought to respond that that is one of the issues on which we can't really offer specific comments or a conclusion.

I think there are legitimate concerns here. Whether those concerns would be best addressed legislatively, again, I would like to reserve. There certainly is a concern about adequate funding; but how that problem is best addressed——

Senator MITCHELL. Well, then, without expressing an opinion, would you briefly summarize the arguments for such legislation and the arguments against it?

Mr. ROSS. Well——

Senator **Mitchell**. That is a politician's dream, to be asked only to give both sides of the question without giving a definitive answer.

Mr. **Ross**. A politician as well as a lawyer.

Senator **Mitchell**. That's right.

Mr. **Ross**. The arguments really would depend on the character of the legislation; but let me hypothesize that the proposed legislation would be to adopt ERISA-type guidelines for what we have characterized as a "defined-dollar-benefit approach" to postretirement benefits. What you would be doing would essentially be establishing a parallel or companion system for funding postretirement benefits, and again parallel and companion to the system we have today for funding pension benefits.

The argument, I suppose, for that is that the need for health benefits among retirees is clear, substantial and important, and one that Government might legitimately concern itself with and try to support. I suppose the argument against that is predominately a revenue argument: Can the government afford that sort of expenditure?

Now, one might try to mix the options there and suggest, Well, perhaps part of the cost could come out of the tax revenues that are today effectively dedicated to pension benefits; in other words, regard the pension system as providing a pool of dollar benefits to retirees. And part of that pool might be drawn upon to provide health benefits, as opposed to just general cash benefits.

As to that sort of legislation, we have not yet reached a conclusion; but certainly, in terms of the revenue issues, it is something that we would find more attractive.

Senator **Mitchell**. But do you think it would, under any circumstances, be proper for Congress to regulate the provisions of benefits without providing improved tax treatment for employers?

Mr. **Ross**. That is, again, an issue as to which we haven't reached a specific conclusion; but I certainly would have concern about that and the effect it would have on an emoloyer's willingness to provide health benefits for retirees. One can make the costs of undertaking such programs so prohibitive that they simply aren't undertaken, and has health policy, and specifically retirement health policy, been advanced in those circumstances? I think there are very legitimate concerns in that regard.

Senator **Mitchell**. OK, thank you, Mr. Ross. I have no further questions. Senator Heinz had to take a phone call, but we will return. Would you mind if we seated the next panel?

Mr. **Ross**. Not at all.

Senator **Mitchell**. Would you wait until Senator Heinz gets back, in the event he has further questions for you?

Mr. **Ross**. Certainly. I would be happy to.

Senator **Mitchell**. Thank you.

The next panel consists of Pamela McCann with the RCA Corp.; Carl Lindquist, United Technologies Corp.; and Robert Reddington, American Telephone & Telegraph Co. Would those three persons please come forward. [Pause.]

Good afternoon, Ms. McCann, Mr. Lindquist, and Mr. Reddington. I am going to have to ask you to pause for just a moment; there is a vote in progress on the Senate floor, and Senator Heinz

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and I will have to go over for that vote. We will have to have a brief delay. I am just going to check with the Senator on whether he wants to stay and try to keep the hearing going. So, if you don't mind waiting just a moment; and if we do both leave now, one of us will return as soon as possible to resume the hearing. I think it is best to do it this way, rather than interrupt you after just a few moments.

[Whereupon, at 3:28 p.m., the hearing was recessed.]

AFTER RECESS

Senator HEINZ. Our hearing will come to order.

Why don't you just stay where you are; but if Mr. Ross could just take that spare chair there, I have one or two other questions I would like to pose to him.

Mr. Ross, thank you for being so patient; I am sorry about the interruptions, but there is no way we can preclude them.

Let me ask you this: If we provide tax-favored prefunding with ERISA-like protections, should we mandate prefunding for employers who provide postretirement medical benefits?

Mr. ROSS. Our general inclination—though, again, that is one of the issues on which I should indicate that we are still speaking tentatively—would be that, yes, that should be. Certainly it is clear that tax advantages should be conditioned on a fixed employer liability to provide benefits and on specifically defined benefits. Tentatively, again, it would seem that it should also be conditioned on adequate funding to secure those benefits.

Senator HEINZ. You mentioned the defined-health-benefit approach would be difficult to set minimum standards for, and I am inclined to agree with that.

Can you elaborate on the problems of setting vesting, accrual, or funding rules for this type of benefit?

Mr. ROSS. Certainly, Mr. Chairman, I think the basic problem is how does one translate benefits that are stated as a particular type or level of coverage into incremental portions of that type or level of coverage; if the ultimate intended benefit is, as I say, a type or level of coverage, what does 50-percent vesting of such coverage mean?

That concept is much more easily understood when you are talking about dollar amounts, where that 50 percent makes sense.

Senator HEINZ. Half a pacemaker?

Mr. ROSS. Certainly. Half your teeth get dental care and the other half don't. One can introduce all sorts of sort of silly spinoffs, I suppose, on what that would mean. Perhaps there are intelligible ones as well, and that is something that we are working on.

Senator HEINZ. Is it an insoluble problem, or just difficult?

Mr. ROSS. We are inclined to think it is at least very difficult. I guess I should not say at this stage that we believe it insoluble, but at the least very difficult.

Senator HEINZ. You prefer defined dollar contribution or benefit approaches in prefunding retirement medical benefits because of the relative ease of applying minimum standards, as I understand it. Is that right?

Mr. Ross. That is one of the benefits, but I should stress that it is not the only benefit. I think the cost containment benefit is also important to keep in mind.

Senator Heinz. Could that be handled by raising limits on contributions and accruals for pension plans which now have minimum standards?

Mr. Ross. I am sorry, Mr. Chairman, I lost the thread of the question.

Senator Heinz. Could a defined-dollar approach, a defined-dollar contribution approach, or I suppose even a defined-dollar benefit approach, be achieved simply by raising the limits on contributions and accruals for pension plans which now have minimum standards? That is to say, existing ERISA-type styled pension plans?

Mr. Ross. In a sense, that is also one of the benefits of that approach, in that it fits so readily with the existing pension system. And one might modify, as you say, the contribution and benefit levels of that system.

Senator Heinz. Well, since it is easy, and since anything that is easy usually has some kind of wrinkle to it, what would we be sacrificing if we did that?

Mr. Ross. I am not sure it would be a sacrifice. I mean, the advantage in the health benefit approach is that one knows, in a sense, what one is getting. If you are instead told that when you retire you will receive *x* dollars per month or per year, that you will have that amount to spend on health benefits, it is not clear what that translates into in terms of health coverage. You are taking a risk that health care costs will grow more rapidly than your contribution amount, if it is a defined contribution approach, or that your defined benefit will simply not be adequate at that point to pay for the health care that you desire and need when you retire. I think that is the principal downside of a benefit approach that focuses on a dollar benefit amount or a contribution sort of bank.

Senator Heinz. Very well. I may well develop some additional questions for you as the result of our next two panels' witnesses; but let me thank you for your testimony and for your responses. They have been very much to the point.

Mr. Ross. My pleasure, Mr. Chairman. We will be happy to respond to any additional questions.

Senator Heinz. Very well.

Our next panel, who is already seated, is Pamela McCann of RCA, Carl Lindquist of United Technologies, and Robert Reddington of AT&T. Ms. McCann and gentlemen, we welcome you, and Ms. McCann, would you please proceed with your testimony.

STATEMENT BY PAMELA W. McCANN, STAFF VICE PRESIDENT AND ASSISTANT TREASURER, RCA CORP., NEW YORK, NY

Ms. McCann. Thank you, Mr. Chairman.

My name is Pamela McCann. I am a staff vice president and assistant treasurer of RCA Corp. RCA is engaged in electronics, communications, and entertainment. My responsibilities include the investment of RCA's pension and welfare plan assets, which exceed

$2 billion, the development of funding policies for those plans, and the management of RCA's Investor Relations Program.

I am here today to discuss RCA's funding of post-retirement benefits.

In February, 1985, the Washington Business Group on Health surveyed 200 large corporations on issues related to retiree health benefits. Of the 131 companies responding to the survey, 95 percent indicated that they offered medical coverages to retirees. However, only 5 percent of the companies prefund for the retiree health benefits. The large majority of companies use pay-as-you-go or terminal funding methods.

Since 1959, RCA has been providing life and health insurance benefits to retired domestic employees. This plan provides life insurance for retirees and hospital, surgical, and medical benefits for retirees and their dependents. Approximately 19,000 retired employees are covered by the program.

As early as 1962, RCA was using an actuarially-based funding method to accrue for future liabilities. Contributions have been deposited in a special insurance continuance account held by a major insurance company.

Two recent events have prompted RCA to undertake a review of its funding policy for retiree medical and life insurance coverages:

In 1984, the financial accounting standards board proposed specific disclosures for accounting for post-retirement life and medical insurance. The proposal indicates that the pay-as-you-go or terminal funding for these benefits may not be acceptable in the future.

In addition, the FASB proposal indicated that the liability for such benefits should be reflected in corporate balance sheets.

Since RCA has been prefunding, the impact of the proposed accounting regulations might be minimized; but FASB has not yet defined acceptable cost methods for determining the full extent of the liability or the proper level of prefunding.

The 1984 Deficit Reduction Act further complicated the funding issue by imposing limits on the amount of deductible contributions that can be made for prefunding post-retirement life and medical benefits. The provisions are effective for contributions paid or accrued after December 31, 1985. In addition, DEFRA imposes an unrelated business income tax on investment earnings, on funds in excess of allowable reserves.

In view of the somewhat conflicting contraints of increased liability disclosure and more stringent funding limits, RCA has undertaken a review of its funding policy for post-retirement medical and life insurance programs. We have been asked by this committee to share the framework of our program for review.

The objectives of the funding policy are three:

First, to develop a means of using existing reserves to continue to make payments for post-retirement health benefits;

Second, to utilize a vehicle that will permit RCA to fund to post-retirement benefits in a tax-effective way;

And third, to establish a vehicle that will continue to permit cost recovery under Federal Government contracts for amounts funded during the working lives of employees.

The study will analyze the magnitude of the post-retirement medical and life insurance liability, both currently and over time, as the demographics of the corporation are expected to change.

Several variables will be studied and tested for appropriateness, including the following:

Inflation—projected under at least three economic scenarios.

Salary increases—comprised of inflation, productivity gains, and merit increases.

Portfolio returns—which will reflect real returns available on specific classes of financial assets.

Decrement rates for mortality and retirement turnover.

Overall growth for RCA.

Future increases in medical costs.

The total liability will be calculated using best estimate assumptions. The framework utilizes a 10-year time horizon. An acceptable level of funding will then be determined which will meet the projected liability within all of the constraints imposed by DEFRA and IRS regulations.

Three alternatives are being analyzed for the ability to meet the objectives of this study: Continuation of the current insurance arrangement; establishment of a VEBA; and utilization of a separate account under the Internal Revenue Code section 401(h).

The overall goal of the study is to develop a cohesive set of plan design, accounting and funding policies for retiree welfare benefit plans.

In summary, RCA believes a sound funding policy must be adopted which will establish a long-term financial plan to meet its welfare benefit obligations.

I thank you for the opportunity to appear before you.

Senator HEINZ. Ms. McCann, thank you very much.

Mr. Lindquist.

[Ms. McCann's written testimony follows:]

TEXT OF PRESENTATION TO
SENATE FINANCE SUB-COMMITTEE ON
FINANCING OF POST-RETIREMENT BENEFITS

July 29, 1985

P. W. McCann
Staff Vice President and Assistant Treasurer
RCA Corporation

FINANCING OF POST-RETIREMENT BENEFITS

In February, 1985, the Washington Business Group on Health surveyed 200 large corporations on issues related to retiree health benefits. Of the one hundred thirty-one companies responding to the survey, 95% indicated that they offered medical coverage for retirees. However, only 5% of the companies prefund for the retiree health benefits. The large majority of companies use "pay-as-you-go" or terminal funding methods.

Since 1959, RCA has provided life and health insurance benefits to retired domestic employees. This plan provides life insurance for retirees and hospital, surgical and medical benefits for retirees and their dependents. Approximately 19,000 retired employees are covered by the program.

As early as 1962, RCA was using an actuarially based funding method to accrue for future liabilities. Contributions have been deposited into a Special Insurance Continuance Account held by a major insurance company.

Two recent events have prompted RCA to undertake a review of its funding policy for retiree medical and life insurance coverages. In 1984, the Financial Accounting Standards Board (FASB) proposed specific disclosures for accounting for post-retirement life and medical insurance. The proposal indicates that the "pay-as-you-go" or terminal funding for these benefits will not be acceptable in the future. In addition, the FASB proposal indicated that the liability for such benefits should be reflected in corporate balance sheets. Since RCA has been prefunding, the impact of the proposed accounting regulations might be minimized, but FASB has not yet defined acceptable cost methods for determining the full extent of the liability or the proper level of prefunding.

The 1984 Deficit Reduction Act further complicated the funding issue by imposing limits on the amount of deductible contributions that can be made for prefunding post-retirement life and medical benefits. The provisions are effective for contributions paid or accrued after December 31, 1985. In addition, DEFRA imposes an unrelated business income tax on investment earnings on funds in excess of allowable reserves.

In view of the somewhat conflicting constraints of increased liability disclosure and more stringent funding limits, RCA has undertaken a review of its funding policy for post-retirement medical and life insurance programs. We have been asked to share with this Committee the framework for the review.

The objectives of the funding policy study are:

1. To develop a means of using existing reserves to continue to make payments for post-retirement health benefits.

2. To utilize a vehicle that will permit RCA to fund for post-retirement benefits in a tax-effective way.

3. To establish a vehicle that will continue to permit cost recovery under federal government contracts for amounts funded during the working lives of employees.

The study will analyze the magnitude of the post-retirement medical and life insurance liability, both currently and over time as the demographics of the corporation are expected to change. Several variables will be studied and tested for appropriateness including:

- Inflation projected under at least three economic scenarios.
- Salary increases comprised of inflation, productivity gains and merit increases.
- Portfolio returns which will reflect real returns available on specific classes of financial assets.
- Decrement rates for mortality and retirement turnover.
- Overall population growth for RCA corporation.
- Benefit levels reflecting assumed future changes in medical and life insurance plan design.
- Future increases in medical costs.

The total liability will be calculated using "best estimate" assumptions. The framework utilizes a 10-year time horizon.

An acceptable level of funding will then be determined which will meet the projected liability within all of the constraints imposed by DEFRA and IRS regulations.

Three funding alternatives are being analyzed for their ability to meet the objectives of the study.

1. Continuation of the current insurance arrangement.
2. Establishment of a trust agreement with an independent trustee providing for a voluntary employee benefit association (VEBA).
3. Utilization of a separate account under the RCA Retirement Plan for the payment of medical benefits as permitted by the Internal Revenue Code Section 401(h).

Under any of these alternatives, however, additional administrative steps must be taken to assure full compliance with tax and accounting regulations.

The overall goal of the study is to develop a cohesive set of plan design, accounting and funding policies for retiree welfare benefit plans. Several corporate functions are providing input to the policy development including Finance, Tax, Accounting, Employee Relations and Benefits Administration. Our actuarial consultants and accountants provide significant guidance throughout the process.

In summary, RCA believes a sound funding policy must be adopted which will establish a long-term financial plan to meet its welfare benefit obligations.

July 29, 1985
Pamela W. McCann
Staff Vice President and Assistant Treasurer
RCA Corporation

RCA Executive Biography

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PAMELA W. McCANN
Staff Vice President and Assistant Treasurer
Pension Funds and Employee Benefit
Services

July 1985

Pamela W. McCann was appointed Staff Vice President and Assistant Treasurer, Pension Funds and Employee Benefit Services, of RCA Corporation, on March 3, 1985.

In her present capacity, Mrs. McCann has overall responsibility for RCA's Pension Funds and Employee Benefit Services activity. She reports to Brian J. Heidtke, RCA Vice President and Treasurer.

Previously, Mrs. McCann had been Staff Vice President and Assistant Treasurer, Retirement Funds Administration, of RCA, since October 1983 when she joined the company.

Prior to joining RCA, Mrs. McCann had been Director, Pension and Employee Benefit Investments, for NL Industries in New York since 1980. Before that, she was a Senior Trust Officer with Chemical Bank. Earlier in her career, Mrs. McCann was a Research Analyst with Collins Associates in Newport Beach, Calif.

A native New Yorker, Mrs. McCann was graduated from California State University in 1972 with a B.A. degree in Business Administration. She later earned an M.B.A. degree from Fordham University. She is a member of the Financial Women's Association of New York; New York Pension Officers Group; and Pension Group East. She is also on the Board of Directors of the Jessie Smith Noyes Foundation.

Mrs. McCann is married and lives with her husband in Hastings-on-Hudson, N.Y.

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STATEMENT BY CARL E. LINDQUIST, DIRECTOR OF EMPLOYEE BENEFITS, UNITED TECHNOLOGIES CORP., HARTFORD, CT

Mr. LINDQUIST. I want to thank you for giving me this opportunity to bring our thoughts and concerns to this committee.

United Technologies Corp. operates in a wide range of businesses in the United States—air conditioning, aircraft engines, elevators and escalators, helicopters, automobile components, to name a few. These business units compete in a variety of industries and labor markets with different labor costs and various levels of sensitivities to increases in the cost of labor.

We have approximately 135,000 employees in the United States and 44,000 retirees. Our retiree health coverage ranges from the continuation of the plan for active employees, to a modest Medicare offset plan for retirees, to no company-offered coverage. These variations reflect the differences in the views of the managements of those units concerning the obligation and feasibility of such coverage.

During the past several years we have evaluated the desirability of changing health care coverage for various groups of our retirees. Leaving aside the issue of employer responsibility for such arrangements, several problems have surfaced during our review:

Health care costs are increasing at a rapid rate—significantly faster than the general rate of inflation;

The results of recent litigation indicate that any offering an employer makes could become a permanent commitment, whether that were the employer's intent or not;

Recent tax legislation discourages the funding of retiree health insurance. There are also indications companies may have to report the liability for health care for current and future retirees on their financial statements without being able to fund for that liability;

The health care delivery system itself, and Medicare, are going through major changes. The effects of these changes on the many participants, including employers, are not at all clear.

As a result, we believe that the degree of uncertainty in the health care environment makes it impractical to reach any confident conclusion regarding extending or improving coverage for retirees. For example, to provide coverage now to retirees who have no company-paid coverage would be equivalent to signing a blank check.

In considering legislation, we believe that you should consider the feasibility of financial incentives for funding—funding benefits for future retirees as well as benefits for current retirees. Any funding arrangements and incentives should be flexible enough to permit both employers and employees to participate in the cost of coverage.

If the Congress feels compelled to adopt some form of legislative guarantee to retirees on health insurance, it should be of a funded dollar amount rather than a specific plan of benefits. The health care delivery system is too dynamic to make long-term commitments for such items as surgical schedules, room and board payments, and the like.

Of real concern to us is what the Federal Government will do with Medicare in the future. Will private employer retiree health plans be looked to for payments first and Medicare second? We saw how easily this happened for active employees over age 65. Assurances in this regard would be very helpful.

Although the provision of health care benefits has many similarities to the protection of pension benefits, it is dissimilar in that retirees are a high cost, high utilization group, and the costs are greatly influenced by outside forces—the health care system and government programs. This makes your challenge of drafting solid legislation very difficult.

In summary, it is possible for the Congress to take steps which will protect and foster employer-provided retiree health benefits. However, to encourage the growth of these plans, employers must be given the financial tools which to limit their liability and to modify future cost accruals.

Thank you, Senators.

Senator HEINZ. Mr. Lindquist, thank you very much.

Mr. Reddington.

[Mr. Lindquist's written testimony follows:]

STATEMENT OF

CARL E. LINDQUIST
DIRECTOR-EMPLOYEE BENEFITS
UNITED TECHNOLOGIES CORPORATION

BEFORE THE
COMMITTEE ON FINANCE
U.S. SENATE

RETIREE HEALTH INSURANCE AND ITS FUNDING

(SEPTEMBER 9, 1985)

UNITED TECHNOLOGIES CORPORATION OPERATES IN A WIDE RANGE OF BUSINESSES IN THE UNITED STATES -- AIR CONDITIONING, AIRCRAFT ENGINES, ELEVATORS AND ESCALATORS, HELICOPTERS, AUTOMOBILE COMPONENTS -- TO NAME A FEW.

THESE BUSINESS UNITS COMPETE IN A VARIETY OF INDUSTRIES AND LABOR MARKETS WITH DIFFERENT LABOR COSTS AND VARIOUS LEVELS OF SENSITIVITY TO INCREASES IN THE COST OF LABOR.

WE HAVE APPROXIMATELY 135,000 EMPLOYEES IN THE UNITED STATES AND 44,000 RETIREES.

OUR RETIREE HEALTH COVERAGE RANGES FROM CONTINUATION OF THE PLAN FOR ACTIVE EMPLOYEES, TO A MODEST MEDICARE OFFSET PLAN FOR RETIREES, TO NO COMPANY-OFFERED COVERAGE. THESE VARIATIONS REFLECT THE DIFFERENCES IN THE VIEWS OF THE MANAGEMENTS OF THOSE UNITS CONCERNING THE OBLIGATION AND FEASIBILITY OF SUCH COVERAGE.

DURING THE PAST SEVERAL YEARS WE HAVE EVALUATED THE DESIRABILITY OF CHANGING HEALTH CARE COVERAGE FOR VARIOUS GROUPS OF OUR RETIREES. LEAVING ASIDE THE ISSUE OF EMPLOYER RESPONSIBILITY FOR SUCH ARRANGEMENTS, SEVERAL PROBLEMS HAVE SURFACED DURING OUR REVIEW.

- HEALTH CARE COSTS ARE INCREASING AT A RAPID RATE -- SIGNIFICANTLY FASTER THAN THE GENERAL RATE OF INFLATION.

- THE RESULTS OF RECENT LITIGATION INDICATE THAT ANY OFFERING AN EMPLOYER MAKES COULD BECOME A PERMANENT COMMITMENT, WHETHER THAT WERE THE EMPLOYER'S INTENT OR NOT.

- RECENT TAX LEGISLATION DISCOURAGES THE FUNDING OF RETIREE HEALTH INSURANCE. THERE ARE ALSO INDICATIONS COMPANIES MAY HAVE TO REPORT THE LIABILITY FOR HEALTH CARE FOR CURRENT AND FUTURE RETIREES ON THEIR FINANCIAL STATEMENTS WITHOUT BEING ABLE TO FUND FOR THE LIABILITY.

- THE HEALTH CARE DELIVERY SYSTEM ITSELF, AND MEDICARE ARE GOING THROUGH MAJOR CHANGES. THE EFFECTS OF THESE CHANGES ON THE MANY PARTICIPANTS, INCLUDING EMPLOYERS, ARE NOT AT ALL CLEAR.

AS A RESULT, WE BELIEVE THAT THE DEGREE OF UNCERTAINTY IN THE HEALTH CARE ENVIRONMENT MAKES IT IMPRACTICAL TO REACH ANY CONFIDENT CONCLUSION REGARDING EXTENDING OR IMPROVING COVERAGE FOR RETIREES. FOR EXAMPLE, TO PROVIDE COVERAGE NOW TO RETIREES WHO HAVE NO COMPANY-PAID COVERAGE WOULD BE EQUIVALENT TO SIGNING A BLANK CHECK.

IN CONSIDERING LEGISLATION, WE BELIEVE THAT YOU SHOULD CONSIDER THE FEASIBILITY OF FINANCIAL INCENTIVES FOR FUNDING -- FUNDING BENEFITS FOR FUTURE RETIREES AS WELL AS BENEFITS FOR CURRENT RETIREES. ANY FUNDING ARRANGEMENTS AND INCENTIVES SHOULD BE FLEXIBLE ENOUGH TO PERMIT BOTH EMPLOYERS AND EMPLOYEES TO PARTICIPATE IN THE COST OF COVERAGE.

IF THE CONGRESS FEELS COMPELLED TO ADOPT SOME FORM OF LEGISLATED GUARANTEE TO RETIREES ON HEALTH INSURANCE, IT SHOULD BE OF A FUNDED DOLLAR AMOUNT RATHER THAN A SPECIFIC PLAN OF HEALTH BENEFITS. THE HEALTH CARE DELIVERY SYSTEM IS TOO DYNAMIC TO MAKE LONG-TERM COMMITMENTS FOR SUCH ITEMS AS SURGICAL SCHEDULES, ROOM AND BOARD PAYMENTS, AND THE LIKE.

OF REAL CONCERN TO US IS WHAT THE FEDERAL GOVERNMENT WILL DO WITH MEDICARE IN THE FUTURE. WILL PRIVATE EMPLOYER RETIREE HEALTH PLANS BE LOOKED TO FOR PAYMENTS FIRST AND MEDICARE SECOND? WE SAW HOW EASILY THIS HAPPENED FOR ACTIVE EMPLOYEES OVER AGE 65. ASSURANCES IN THIS REGARD WOULD BE VERY HELPFUL.

ALTHOUGH THE PROVISION OF HEALTH CARE BENEFITS HAS MANY SIMILARITIES TO THE PROTECTION OF PENSION BENEFITS, IT IS DISSIMILAR IN THAT RETIREES ARE A HIGH COST, HIGH UTILIZATION GROUP, AND THE COSTS ARE GREATLY INFLUENCED BY OUTSIDE FORCES -- THE HEALTH CARE SYSTEM AND GOVERNMENT PROGRAMS. THIS MAKES YOUR CHALLENGE OF DRAFTING SOLID LEGISLATION VERY DIFFICULT.

IN SUMMARY, IT IS POSSIBLE FOR THE CONGRESS TO TAKE STEPS WHICH WILL PROTECT AND FOSTER EMPLOYER-PROVIDED RETIREE HEALTH BENEFIS. HOWEVER, TO ENCOURAGE THE GROWTH OF THESE PLANS, EMPLOYERS MUST BE GIVEN THE FINANCIAL TOOLS WITH WHICH TO LIMIT THEIR LIABILITY AND TO MODIFY FUTURE COSTS ACCRUALS.

SUMMARY OF COMMENTS ON RETIREE HEALTH INSURANCE AND FUNDING

THERE ARE PROBLEMS ASSOCIATED WITH RETIREE HEALTH INSURANCE AND ITS FUNDING:

- RAPIDLY ESCALATING COST OF HEALTH CARE
- RESULTS OF RECENT LITIGATION RAISE DOUBTS ABOUT THE POSSIBILITY OF PLAN CHANGES IN THE FUTURE
- RECENT TAX LEGISLATION DISCOURAGES FUNDING
- MEDICARE AND THE HEALTH CARE SYSTEM ARE GOING THROUGH MAJOR CHANGES

IN PREPARING LEGISLATION THE FOLLOWING SHOULD BE CONSIDERED:

- FUNDING SHOULD BE POSSIBLE FOR BOTH EMPLOYERS AND EMPLOYEES
- IT IS NOT POSSIBLE TO GUARANTEE A PLAN OF BENEFITS -- HOSPITAL DAYS, SURGICAL SCHEDULES
- ASSURANCE ON THE FUTURE ROLE OF MEDICARE WILL BE IMPORTANT

Carl E. Lindquist
United Technologies Corporation
Hartford, Connecticut

September 9, 1985

STATEMENT BY ROBERT F. REDDINGTON, MANAGING ACTUARY, AMERICAN TELEPHONE & TELEGRAPH CO., PISCATAWAY, NJ, ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Mr. REDDINGTON. Good afternoon, Chairman Heinz.

I am Robert F. Reddington, Managing Actuary for AT&T, and I am appearing here today on behalf of the ERISA Industry Committee.

The ERISA Industry Committee, or ERIC, represents the concerns of over 100 major U.S. employers who administer comprehensive retirement security and employee benefit programs on behalf of some 9 to 10 million active and retired workers and their families.

Again, I would like to thank you for allowing us to participate in this forum.

My testimony today, as an actuary, will seek to outline some of the components of cost that are driving the emerging liabilities. I will not read from my prepared text, but I will move to the charts associated with that text so that we can have an idea of what is happening.

Senator HEINZ. Very well; but, without objection, your entire text will be made part of the record.

Mr. REDDINGTON. Yes, I think it should be. Thank you.

The first chart simply indicates, by industries, what level of approximate cost companies are paying today. And the source of these data are primarily Chamber of Commerce studies and certain phone calls that I made.

If we look in the area of about 6 percent of pay, we see what the magnitude of the current costs are.

Chart 2 traces a growth for a particular plan with which we had the data available. I am using AT&T statistics, not for any reason other than that they were readily available to me, and I propose that they are representative of large, well-designed benefit plans.

We see a rather strong growth from 1970 to 1984, from roughly 2.5 to about 6 percent. And I think this is probably comparable to what happens in a lot of other areas.

Now, to see what drives some of these things, I think we really have to look at what happens in the consumer price index. We are all familiar with the ravages of inflation that have occurred in the last 10 to 15 years, and I therefore looked at what was the effective change in the consumer price index, and then I took out the medical component to demonstrate that the medical component is proportionately larger and has been higher over all those periods of time. I don't think it is necessarily important as to whether it is exactly 126 percent of the other; but I think it is important to understand that the components of cost in this area are in fact higher.

The next chart talked about some consumer price index increases and split up certain components of the medical care. We see physician services and hospital room services and hospital wages, and also we can contrast that with the increase in premiums.

Chart 5 talks about the estimated increase in medical claims by age, and the simple indication of this was to tell you that, as

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common sense indicates, as people get older they tend to have higher medical claim costs.

Senator HEINZ. Just one question. I assume that the reason that the annual increases in plan costs per employee are larger is because of increases in coverage.

Mr. REDDINGTON. Well, partly that, and partly because of the fact that there are more claims. There is more utilization as people become sick and do have to go to these plans for relief.

The source of this, I believe, was our insurance company carrier data. We really didn't analyze the data. Medical data is very difficult to secure, never mind analyze, and we are not sure of all the reasons, but we have an indication. There are other studies. And we also noted a substantial part of medical claims are at or near death; so as one gets older, we do have that probability happening. But there are scanty data.

The next chart indicates an average premium before 65 and at 65. And obviously, the difference is the fact that Medicare comes in and pays part of that premium. Now, I don't know what it would have been had Medicare not been there; but if it were $1,700 or some other rough number—and, again, these are averages—we can see that Medicare does pay a substantial part of this postretirement situation. Of course, here, we are arguing who is paying the price.

The next chart was an indication to show that, as companies get more and more retired people, they get more and more costs associated with the retired. Some of the lack of emphasis on postretirement medical was the fact that there weren't enough people there to whom we were paying claims, so that it was a problem that did not demand the attention that it now gets as companies age and mature.

Another chart shows the rough number of retired people, and this was based on those data that we had on the new company.

The last chart, of course, simply shows the various funding methods and indicates that if you don't make any advance payment your costs go up. If you recognize that at retirement you have lower costs, then the level line is the classic insurance principle "pay more now and pay less later." Thank you.

Senator HEINZ. Very well. Thank you very much.

[Mr. Reddington's written testimony follows:]

ERIC

THE
ERISA
INDUSTRY
COMMITTEE

FINANCING RETIREE HEALTH COVERAGE

ROBERT F. REDDINGTON

A. T. & T.

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON SAVINGS, PENSIONS AND INVESTMENT POLICY

SEPTEMBER 9, 1985

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FINANCING RETIREE HEALTH COVERAGE

In recent years, the magnitude of company paid health insurance payments for both active and retired employees, as well as for dependents, has become of increasing concern to corporate management. For many companies, insurance payments as a percent of pay had reached the 5% to 8% range by 1983 (Chart 1). In that year the cost of medical coverage to AT&T was 6.2%.

The lack of concern by management only a few years earlier reflects the fact that health care costs were much lower then. As a percent of pay, AT&T's costs were 2.5% in 1970, increasing steadily to 4.2% in 1980 and finally 5.9% of pay in 1984 (Chart 2). The 5.9% for 1984 represents a small decrease from 6.2% for 1983, which may have been partly due to the AT&T divestiture at the beginning of 1984.

During most of this period overall inflation as measured by the Consumer Price Index was high. However, the medical care component of the CPI has increased even more rapidly than the overall CPI, having averaged about 15% above overall CPI increases (Charts 3 and 4). And if that hasn't been enough, employer costs have been increasing at rates significantly greater than even those of the medical care component of the CPI (Chart 4). For AT&T, medical care costs during the 1970's and early 1980's have increased on average more than 15% per year in terms of total dollars and also in terms of dollars spent per employee.

A part of the increasing cost to AT&T relates to the fact that medical claims per retired employee tend to increase by age (Chart 5), except at the very high ages and of course at age 65 when medicare eligibility begins.

It is a common practice for management to relate all employee benefit costs of both active and retired employees to the number or payroll of active employees. Thus, those companies with a significant retired life population will most likely have relatively high medical claims when related to the number of active employees. At AT&T, we compared the total medical claims of the active and retired employees of three large subsidiaries, call them companies A, B, and C (Chart 7). We related these claims to the number of active employees in each company. Company A has no retirees, Company B has 15% retirees and Company C has 25% of its population as retirees. Not surprisingly, the medical claims per active employee for Company B were 35% higher than for Company A, and for Company C the corresponding figure was 100% higher than for Company A. If the retired population of a company is expected to continue to grow relative to the active population, there will likely be serious cost implications in the future.

Today AT&T has about 57,400 retired employees as compared to 27,200 ten years ago. We estimate that the number of retired employees will increase from the present 57,400 to about 119,300 during the next 10 years (Chart 8), thus posing a significant medical cost problem.

Presently AT&T and most other companies do not advance fund the post retirement medical coverage, but rather pay for the claims or coverage one year at a time. This is commonly referred to as a "pay-as-you-go" basis because the company's expense relates only to the medical claim payments for the year, with a margin for contingencies and expenses. Only a small percentage of companies presently advance fund these benefits.

It may be helpful to analyze the long term cost implications of advance funding on an actuarial basis versus not advance funding on an actuarial basis (Chart 9). From the chart we can see that total company expense as a percent of payroll on a pay-as-you-go basis will ultimately increase to a relatively high level.

The second cost method we will look at is the "terminal funding" method. Under this method the company does not incur any cost for the post retirement coverage until the employee retires. At retirement, in a single payment, the company incurs the full estimated cost of all the medical claims anticipated to be paid over the newly retired employees remaining lifetime. The "terminal funding" approach has a higher cost to the company at retirement than does the "pay-as-you-go" approach but lower costs ultimately. Initially, the cost of the post retirement coverage under both methods will be zero if there are no retired employees. A very important consideration with respect to the "terminal funding" method is the greater security of the retired employee since the benefit is fully paid for at retirement and not dependent on the continued financial success of the company.

The third and last cost method is the family of actuarial cost methods which tend to budget the cost of the post retirement coverage on a level basis during the employee's working career. This method provides the greatest security to employees because funds are being set aside before retirement occurs. The level actuarial cost methods produce higher costs initially but lower ones ultimately than the two other methods shown. The level actuarial cost methods are also used to advance fund pension plan benefits during the active service of employees. Neither "pay-as-you-go" financing nor "terminal funding" are allowed in the funding of pension plans.

In order to determine costs using a level actuarial cost method, the actuary must make assumptions in his calculation as to the amount of future post retirement medical claims for the present active employees and for any dependent coverage. There are many variables to be considered which will affect future medical claims such as medical care inflation, advances in medical technology, the impact of competition in the medical field and the amount of medical care that will be provided by medicare. With this in mind, we have estimated the cost to AT&T as a percent of pay of advance funding the post retirement medical coverage of present active employees. Costs were determined as a percent of pay on three bases or scenarios. Under Scenario 1, we have assumed that medical claims per individual will increase in the future initially at 10.5% per year, with such annual increases grading down to 7.5% per year after about 15 years. Scenario 2 is based on medical claims per individual increasing initially at 8% per year with the annual increases grading down to 5% after 15 years. In Scenario 3 the corresponding increases are 5.5% initially, grading down to 2.5% after 15 years.

The advance funding costs as a level percentage of payroll are estimated to be:

Scenario	Cost as a Percent of Pay
1	10.9%
2	5.0%
3	2.6%

In addition to the above assumptions, the estimated costs are also based on medical claims increasing for advancing age except at the very high ages. The interest rate assumption for discounting purposes is 8% in the first year grading down to 5% after 15 years. Assumptions were also made with respect to mortality, retirement, future pay increases, other future anticipated separations from service and dependent coverage. The above estimates do not reflect future medical claims of the present retired employees.

Robert F. Reddington
AT&T
July 29, 1985

Chart 1

COMPANY HEALTH INSURANCE PAYMENTS AS A PERCENT OF PAYROLL FOR 1983

ALL INDUSTRIES	6.4%
MANUFACTURING	7.7%
NON-MANUFACTURING	5.4%
PUBLIC UTILITIES	5.9%
AT&T	6.2%

Chart 2

AT&T

MEDICAL EXPENSE PLAN

COSTS AS A PERCENT OF PAY

1970	2.5%
1975	3.6%
1980	4.2%
1983	6.2%
1984	5.9%

Chart 3

COMPARISON OF OVERALL CONSUMER PRICE INDEX TO MEDICAL COMPONENT OF CONSUMER PRICE INDEX

	OVERALL CPI	MEDICAL COMPONENT	RATIO
LAST 10 YEARS	7.7%	9.7%	1.26%
LAST 20 YEARS	6.2%	7.6%	1.23%
LAST 30 YEARS	4.6%	6.1%	1.33%
LAST 40 YEARS	4.5%	5.7%	1.27%
LAST 49 YEARS	4.2%	4.9%	1.17%

Chart 4

AT&T

ANNUAL INCREASE IN MEDICAL EXPENSE PLAN COSTS FROM 1970-1984

1.	TOTAL PLAN (1970-1983)	18.2% PER YEAR
2.	PER ACTIVE EMPLOYEE	16.8% PER YEAR

CONSUMER PRICE INCREASES FROM 1970-1984

3.	CONSUMER PRICE INDEX	7.3% PER YEAR
4.	MEDICAL CARE COMPONENT OF CONSUMER PRICE INDEX	8.5% PER YEAR
5.	PHYSICIANS SERVICES	8.4% PER YEAR
6.	HOSPITAL ROOM	11.5% PER YEAR
7.	HOSPITAL WAGES	8.3% PER YEAR

Chart 5

AT&T

ESTIMATED INCREASE IN MEDICAL CLAIMS BY AGE

AGE	MALE	FEMALE
55-64	4.1%	1.3%
65-80	3.6%	3.8%
ABOVE 80	PERCENTAGES DECLINE	PERCENTAGES DECLINE

Chart 6

AT&T

JANUARY 1, 1984

ESTIMATED ANNUAL MEDICAL CLAIM COST PER RETIREE

AGE	COMPANY COST PER RETIREE
BELOW AGE 65	$ 1500
ABOVE AGE 65	$ 400

Chart 7

COMPARISON OF MEDICAL EXPENSE PLAN COSTS AMONG VARIOUS AT&T COMPANIES

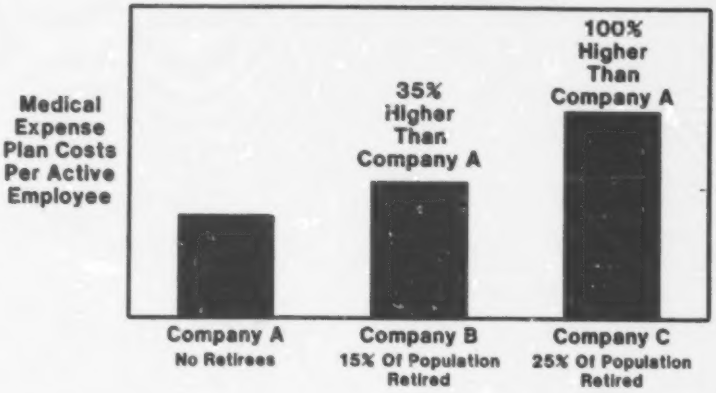


Chart 8

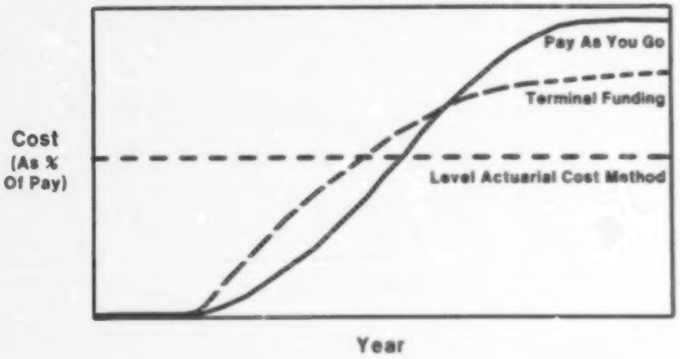
AT&T

NUMBER OF RETIRED EMPLOYEES

10 YEARS AGO	27,200
TODAY	57,400
10 YEARS FROM NOW	119,300

Chart 9

COMPARISON OF COST TRENDS
(As % Of Payroll)
UNDER VARIOUS COST METHODS
Post Retirement Medical Coverage



Senator **Heinz.** Ms. McCann, you have been prefunding your retiree health benefits with an insurer. Can you explain to us how that kind of an arrangement works?

Ms. **McCann.** Yes; we work with the insurance company in determining the level of liability over a reasonable period of time. We use an actuarially based cost method in determining the amount that we want to prefund in any one year. In effect, the policy in place at RCA right now is that we fund for our employees who are age 55 or over, we fund a set amount for each one of those retirees. And then those moneys are deposited in what is called a special insurance continuance account.

Senator **Heinz.** How did DEFRA make this kind of funding more expensive or more difficult for you?

Ms. **McCann.** DEFRA imposes an unrelated business income tax on the reserves that are held by the insurance company; therefore, that became an additional cost to us.

Senator **Heinz.** Now, you mentioned you are studying the alternative of setting up a medical benefit account under the RCA retirement plan, using 401(h). What are the advantages and disadvantages of that approach?

Ms. **McCann.** The advantages of having that funding in the RCA retirement plan is that the assets then become part of the overall fund and are really controlled and invested by RCA within the pension plan. Thereby, one hope is to increase the yield as opposed to what we would earn in an insurance company account; but secondarily, those assets would not be subject to the unrelated business income tax.

Senator **Heinz.** Because you observed the minimum ERISA standards?

Ms. **McCann.** Exactly.

Senator **Heinz.** Now, what about the disadvantages of that approach?

Ms. **McCann.** Well, the disadvantages are that, again, we are subject to restrictions with respect to minimums and maximums under ERISA for the amounts of money that we can actually put into the pension plan in any one year. So the amount that we can prefund for postretirement medical benefits is still limited within the scope of how much we are allowed to contribute to the pension plan in total.

Senator **Heinz.** How tightly is it limited? Does the shoe pinch?

Ms. **McCann.** For RCA at this point, the answer to that, Mr. Chairman, is no. We believe we have enough room to continue to fund under what we consider to be sound actuarial principles. Again, the purpose of the study that we are now in the middle of is to determine whether or not that pinch is any more than we currently think it is.

Senator **Heinz.** If the shoe doesn't pinch, then what are the disadvantages?

Ms. **McCann.** Of prefunding into the 401(h)?

Senator **Heinz.** Yes; is there something else there?

Ms. **McCann.** Not that comes to mind, Mr. Chairman.

Senator **Heinz.** Is anybody cut out?

Ms. **McCann.** No; in fact, we are not restricted in any way in terms of the people that are currently covered under the plan; so we don't believe that there is a disadvantage there, certainly with respect to either the plan design or the people covered by the plan.

Senator HEINZ. Now, you currently prefund specified retirement health benefits, as I understand it. Is that correct?

Ms. McCANN. Yes; we do.

Senator HEINZ. What problems do you have in trying to accurately predict the cost of health benefits 10, 15, 20 years from now, and is there a danger of greatly underfunding?

Ms. McCANN. The problems are those certainly related to any kind of prediction of things like the CPI or medical care cost inflation in and of itself. Very difficult for us to do.

Senator HEINZ. How accurate have you been in the past? [Laughter.]

You are very young; you may not have been there long enough to answer this question.

Ms. McCANN. Well, it has been an interesting study historically to see that we have really been well-funded in the plan, at least enabling us to meet the liabilities. In all honesty, the difficulty we have had in meeting the prediction has been more based on the fact that we have been funding for people from age 55 to normal retirement, and the normal retirement age has been coming down. So that has been more of a significant variable to us than even inflation at this point, although that is extremely sensitive.

So I think, in answer to your question, the main difficulties we have are with respect to the inflation and health care issues—health care inflation, in particular.

Senator HEINZ. If the Congress ERISA-fied retiree health benefits and required vesting and other benefit guarantees, how would this affect your ability and interest in providing these benefits. I gather it is an option you are considering. But if we did do that, what kind of changes should we make?

Ms. McCANN. Well, I think certainly we have to take a look at the funding method that would be allowed, or the acceptable funding methods under the current code, the IRS code, that might be impacted by that kind of change in legislation; so—to get back to your point—to see just how much that shoe is going to pinch, and not to impinge on the funding of a pension plan.

Senator HEINZ. If the shoe didn't pinch, I assume that you would not discard your retiree health benefit plan, that you would be interested in continuing it under that option?

Ms. McCANN. I certainly think that is the position that RCA would be in.

Senator HEINZ. Mr. Lindquist, you mentioned four elements of uncertainty which discouraged you from extending retiree health coverage—namely, rising health costs, recent court cases, the 1984 tax legislation, and the changes in health care delivery. How important a factor was the tax legislation, DEFRA?

Mr. LINDQUIST. I would say it was one of the more important ones as we looked at the issues. I think some of the other uncertainties were there; but, when we began to build the examination of what kind of liabilities we had and how we would address those, it certainly was one that turned us off. We said, "Hey, this is not the time to make changes."

Senator **Heinz**. Well, let me put it to you another way: If we repealed the VEBA changes, would that be enough to encourage you to extend and improve your coverage?

Mr. **Lindquist**. I think that would be. I think it may not be the only answer, but it would be a strong encouragement. Yes.

Senator **Heinz**. You suggested that if Congress legislates benefit guarantees it should be for a cash benefit only and not for a medical benefit. In your judgment, would vesting rules and other guarantees discourage employers from offering retiree health benefits if the guarantee was of a cash amount only?

Mr. **Lindquist**. No; I don't believe so.

Senator **Heinz**. Mr. Reddington, from your testimony it appears that AT&T is concerned about rising costs in its retiree health program, and you have obviously looked at the advantages and disadvantages of prefunding. Why is AT&T choosing not to prefund the retiree health benefit?

Mr. **Reddington**. I didn't appear here in regard to the AT&T management and I am really not privy to those decisions, Mr. Chairman.

What I did, was use the AT&T statistical base to develop statistics for me, as an actuary, to show the emerging liabilities. I am certain that the responsible management such as the benefit planning people are looking at this with the financial people.

Senator **Heinz**. We will submit a question to them for a response to that. I understand your position.

[The questions follow:]

Senator **Heinz**. You mentioned that funding retiree health using actuarial cost methods, as ERISA requires for pensions, provides the greatest security for employees. How do you think employers like AT&T would react if, like ERISA, we required that retiree health benefits be funded this way is they are provided?

Mr. **Reddington**. I can indicate the premise is correct, in my judgment as an actuary, that the more prefunding we have, whether we use a modified approach such as RCA or a full actuarial approach, it enhances the security of the benefit-delivery promise. I cannot answer how AT&T would act or other large employers, because I simply do not know.

Senator **Heinz**. Well, in your own opinion, does it make sense to give active participants benefit protections or vesting?

Mr. **Reddington**. I think it makes some sense. I think, again, we have to discover what the problems are in terms of the emerging liabilities, and then develop sensible guidelines which motivate a solution to the problem. The problem exists; how are we going to pay for it? And we have to make sure that we design systems that encourage the payment and encourage the delivery of these benefits, if that is what our game plan is.

Senator **Heinz**. Since most employers apparently don't think that they really promise these benefits to their active workers, why do they believe they have a liability? I suppose you are the best person to direct that to, Mr. Reddington, unless Mr. Lindquist wants to jump in.

Mr. **Reddington**. I think I need some advice from an expert.

Senator **Heinz**. Let me direct that question at Mr. Reddington.

Why do companies believe they have a liability for their preretirement employees?

Mr. LINDQUIST. I think employees begin to look on these promises as they get closer to retirement as an expectation that they are going to be there. And in that sense, it represents an obligation to the corporation.

On the other hand, I think, what I touched on in my testimony, that that is such a dynamic changing thing, that we don't make promises to days in the hospital or surgical schedules but to provide some kind of coverage for these people. And if you tell them you are going to have it, you probably are going to provide it to them. There are very few times that we make changes, unless we are in bad business conditions, or remove benefit plans. Those things can happen.

Senator HEINZ. Are the accounting changes proposed by the Accounting Board—will they require companies to show as a liability the benefits to non-retired workers?

Mr. REDDINGTON. I am going to pass that one back.

Senator HEINZ. Ms. McCann, do you have the answer to that?

Ms. MCCANN. I'm sorry, Mr. Chairman. You are asking if they are going to impact on the nonretired employees?

Senator HEINZ. Yes.

Ms. MCCANN. To my knowledge, no. I don't believe that is the case.

Senator HEINZ. All right.

Mr. Reddington; some claim that recent trends are making employers nervous about providing retiree health benefits, and many are now shying away. What do you think the Congress should do to help encourage employers to provide or expand retiree health benefits?

Mr. REDDINGTON. Well, from a commonsense approach, I think you have to create the environment that allows the appropriate fiscal responsibility in terms of these matters, such as tax deductions, reasonable tax deductions, and things of that nature.

Senator HEINZ. Do any of you also want to take a crack at that question? It is, What do you think Congress should do at this point to help encourage employers to provide or expand coverage to retiree populations?

I gather there is some sentiment for doing something about the VEBA changes of 1984. That message came through loud and clear. I gather that it is acceptable to employers to have some kind of minimum standards, somewhat like ERISA. And if we go that route, that we should be talking about defined contributions or defined dollar benefits. And then there is the question of whether we should require prefunding. That is kind of the hierarchy of issues. Maybe I have missed one or two; if I have, let me know.

Does anybody want to make a comment on that?

Yes.

Mr. REDDINGTON. I think a bit of history is in order. We didn't wake up one day with pension plans and say, "Fund according to ERISA." What we had was an evolutionary approach where there were large plans and corporations first discovered that they all initially used pay as you go, and then they discovered that these liabilites would emerge and increase and some fiscal integrity was required. So, it was an evolutionary approach in funding programs, and that culminated ultimately with Federal law such as ERISA.

But even before ERISA, most large companies funded their plans well, and the impact of ERISA on those plans was relatively minor in terms of additional funding costs.

I think, analogously, we discovered that the postretirement medical insurance liability was emerging, and people were just starting to look at what to do with it. But it was a matter of discovering the problem first. And then subsequently we had some modifications in the 1984 tax law that may have altered the decisionmaking in some corporations.

But I think what we have to do responsibly is identify the problem and then develop appropriate legislation that encourages a solution to the problem.

Senator HEINZ. Any other comments? Ms. McCann?

Ms. MCCANN. Mr. Chairman, just a comment with respect to coordination of the various inputs to these kinds of decisions. With respect to RCA's study, the fact that we found ourselves in a position where the special insurance account would be subject to unrelated business income tax left us, as corporate citizens who were prefunding, who suddenly had an additional cost at our door and had to start to look to alternatives.

And as I refer to in my comments, we had some conflicting points of view, with DEFRA legislation and proposed FASB legislation. So I think the encouragement from our point of view would be to be very cautious in making sure that the input of Internal Revenue, the input of the accounting standards board, whatever those bodies are, in some way be coordinated.

I think we felt, as a corporation on this particular issue, that the lack of coordination has cost us in terms of administrative costs, legal time, and then the kinds of changes we needed to make in order to continue to fund in a sound way.

Senator HEINZ. Well, that is good advice. And any time you can get Government in full coordinated stride, let me know. [Laughter]

But we will make every effort.

If there are no further comments, I am going to briefly recess the hearing, because there is another vote on. I hope to be back within about 8 minutes.

Any other comments? Because the next panel will be the last group of witnesses.

Mr. Lindquist?

Mr. LINDQUIST. No, that's fine.

Senator HEINZ. All right. Thank you all very much.

The hearing is recessed for between 5 and 10 minutes, and I hope our last panel of witnesses will still be here.

[Whereupon, at 4:18 p.m., the hearing was recessed.]

AFTER RECESS

Senator HEINZ. Ladies and gentlemen, the hearing will reconvene.

Our second panel and last three witnesses are Judith Mazo of the National Council for Multiemployer Pension Plans, Phillip Briggs of the Metropolitan Life Insurance and Robert Maxwell of AARP.

Ms. Mazo, gentlemen, would you please come forward. [Pause]

I am advised that Mr. Briggs flight was delayed. I couldn't help but observe that I have done my best, or the Senate has done its best I guess, to delay the hearing, and maybe he will be able to join us.

Let me ask Ms. Mazo to be our first witness.

STATEMENT BY JUDITH F. MAZO, VICE PRESIDENT AND DIRECTOR OF RESEARCH, MARTIN E. SEGAL CO., NEW YORK, NY, ON BEHALF OF THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

Ms. MAZO. Thank you.

I am Judith Mazo. I am vice president of the Martin Segal Co., which is a national actuarial consulting firm. I am here today on behalf of the National Coordinating Committee for Multiemployer Plans.

The coordinating committee, whose affiliates include more than 140 multiemployer health, welfare, and retirement plans, and the international unions associated with those plans, has been working since 1974, representing the interests of the more than 8 million working and retired people covered by multiemployer plans, on benefits issues, specifically.

I am very pleased to talk to you today about two related points which are outlined in the statement that we gave you earlier.

Basically, we share with you, I think, the conviction that what we need is a renewed and strengthened commitment to a cohesive national retirement-income policy. And I think that retiree health coverage is a very good example, and the current rules surrounding it are a very good example, of the need for some coherence in the policy.

What I wanted to talk about a little bit is the problems that multiemployer health plans face in attempting to finance not only retiree health benefits but health benefits for active workers, for laid-off workers, and for families generally, in light of the constraints imposed by the Deficit Reduction Act.

And then if we have time, I will go through the list of what I consider the really crazy-quilt patchwork of rules pointing in lots of different directions on the issues of retiree health coverage and the problems of funding them.

To understand the dilemma that multiemployer plan sponsors face, in the face of rules stating that they cannot have effective tax-exempt reserves for health benefits, you must understand, I think, the special nature of multiemployer plans.

They are all, by statutory definition, established under collective bargaining agreements that cover union represented people who work for any number from perhaps three to as many as 2,000–3,000 different employers in a given industry. Under the Taft-Hartley Act, they must finance their benefits through the use of a trust fund. Any amounts collected, even if it is then used to purchase insurance, must be put into a trust fund. The trust fund must be governed by a board of trustees with equal representation of employers and union and other employee representatives.

Because since 1948, the multiemployer groups have had trusts to finance their benefits—that is, since the enactment of Taft-Hartley—multiemployer groups have had much more experience, I think, than many corporations had had until recently with the economies that could be achieved through self-financing of benefits, through self-insuring of benefits, and through creative financial design.

Typically, where the money comes from for these benefits is that employers will negotiate with the union to contribute a fixed amount, typically linked to the active worker's activity, which is fixed in the collective bargaining agreement for some stated period of time. A standard formula might be $1 per hour for every covered hour worked goes into the health plan. Perhaps another dollar might go into the pension plan. And that is all part of a negotiated compensation package.

The plan of benefits itself generally will be established by the trustees rather than by the bargaining parties, who negotiate with an understanding on benefits that they want but who do not specify in any great detail. And the reason for that is that the trustees must design a benefit program that they feel they will be able to pay for over a period of 3 years, given that they have no opportunity to go back for more money if their prognostications fall short.

I have indicated, starting on page 3 of the outline, a number of the implications for multiemployer plan design that this basic financing mechanism creates. Benefits are really basically uniform for all members of a bargaining unit. There is no issue, and I don't think anyone has raised any issue, of discrimination in favor of higher paid people.

Moreover, there is a natural tension between labor and management that tends to guarantee that you are not going to have too much money, if you will, put into these plans. And the reason it works this way is that employers have generally no particular interest in putting more money into these plans than they have to; and the union people would just as soon have more money show up as wages and less spent on benefits if they could get the benefit package that they feel that their members want.

I have attached a chart at the end of the statement which shows the variety of different types of eligibility rules that multiemployer plans have that reflect the special consequences of their industries. You may have a rule where $2,000 of earnings in covered work one year buys you health coverage for another year. Often, because the work itself in an industry is sporadic, you have built-in extended coverage for people, which means that you have people having health coverage and their families having health coverage although they are not working to generate income for the plan—in addition to retirees.

I want to talk a little bit about reserves in multiemployer plans, the natures of reserves.

Is that it? Do we stop now?

Senator **Heinz**. Why don't you try to summarize the other key points?

Ms. **Mazo**. OK. Well, the key point, I guess, here is, in terms of retiree health coverage, we estimate that close to 60 percent of the multiemployer plans that our company works with provide some type of retiree coverage. It may vary from simply reimbursing Medicare part B premiums to a full package of benefits covering all retirees including early retirees, depending on the nature of the industry, the money available at a given time, et cetera.

We doubt that many multiemployer plans, and I would say none that our people are directly familiar with, are currently undertaking to prefund over the working people's lifetime, to prefund for retiree coverage. Instead, an attempt is made by maybe 20 to 30 percent of the plans to create reserves to pay for retiree health costs at the time people retire; in other words, a judgment would be made:

> We have 400 retirees now, what are we likely to need for them to continue their coverage for the next 10 years? Let's build a little extra into the contribution rate to try to at least establish some kind of reserve in case there is a strike, an industry decline, a fall-off in contributions, so that we don't have to cut them off even though they are not currently generating income.

I would say a definite minority of plans under current circumstances are attempting that degree of funding. In earlier, happier, less health-care-inflationary times, a much greater attempt was made to establish some sort of reserves. Those were largely used up, particularly during the early eighties when these industries went into a decline and whatever reserves were there were used to maintain health coverage for both active and retired workers. As professional advisers to them, we would like them to be able to start responsibly funding. We don't think most of them could afford it, even if the laws allowed it, right now. But certainly, some shorter term funding for those that could come up with the assets is something that we strongly recommend as advisable for the security, as I said, of both the actives and the retired people.

Senator HEINZ. Is there anything else you would like to add at this point?

Ms. MAZO. I am just prepared to answer any questions you might have, Senator.

Senator HEINZ. Without objection, your entire outline will be a part of the record, and I would also announce that Mr. Briggs' statement of the Metropolitan Life Insurance Co. will also be a part of the record.

Our last witness is Mr. Robert Maxwell of the AARP, bringing up the rear, saving the heavy troops, the heavy guard, for last.

Ms. Mazo's and Mr. Briggs' written testimonies follow:]

National Coordinating Committee for Multiemployer Plans

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Outline of Statement by Judith F. Mazo on behalf of the National Coordinating Committee for Multiemployer Plans, before the Senate Finance Committee Subcommittee on Savings, Pensions and Investment Policy, July 29, 1985

I. Introduction

A. Role and function of the Coordinating Committee.

B. Overall objective: renewed commitment to a cohesive national retirement income policy that focuses on fostering a broad-based private-sector system of fair and adequate benefits to meet basic needs of workers, retirees and their families.

C. Retiree health coverage as an example of the need for coherent policy.

1. The impact of the health plan reserve limits in the amendments to the Internal Revenue Code added by the Deficit Reduction Act of 1984 on multiemployer plan benefits for retirees and others.

2. A list of the broad assortment of recent and pending rules and requirements affecting health benefit plans, illustrating the conflicting demands and pressures on plan sponsors.

II. Multiemployer Health Plans and the Effect of Reserve Limits

A. A brief description of the special character of, and constraints on, multiemployer plans.

1. Established pursuant to collective bargaining agreements to cover union-represented employees working for any number of employers in an industry, often but not always in industries characterized by highly mobile employment.

2. Section 302(c)(5) of the Taft-Hartley Act mandates use of a trust fund, administered by a board of trustees on which the employers and the union have equal representation.

3. Employer contribution rates fixed by bargaining agreements, generally for three-year periods, typically linked directly to the level of activity by covered workers, such as a cents-per-hour rate. There may be one contract or many of them.

4. Typically, plan of benefits developed by the plan trustees rather than the bargaining parties, based on what the plan is expected to be able to afford in light of the anticipated income from negotiated contributions.

B. Implications for multiemployer plan design and operation.

   1. Benefits are basically uniform for all members of a bargaining unit: no discrimination problems.

   2. The natural interplay of labor-management relations and interests assures that employers do not contribute more than what both parties consider absolutely necessary: no tax abuse concerns.

   3. The nature of work in many multiemployer plan industries means that eligibility often automatically extends over periods in which a participant is not actively working and generating plan contributions (see attached chart).

4. With contributions directly linked to the amount of work by active participants, industry contraction automatically reduces plan contribution income, without necessarily reducing plan coverage or benefit obligations. Conversely, an unexpected spurt of covered work automatically produces unanticipated income. With rare exceptions, neither the employers nor the plan trustees can adjust the amount of contributions to fit the plans' actual needs during the term of the labor contract.

5. As the amount of plan contributions is typically negotiated as part of the overall compensation package, amounts contributed for benefits -- including the benefits of retired and laid-off participants -- directly reduce active workers' pay.

6. Dependent coverage is virtually universal, automatic, and non-contributory.

C. Reserves in multiemployer health plans.

1. Incurred claims: not even viewed as a "reserve," but as a current charge against assets.
2. Economic contingencies during contract period.
    a. Decline in contributions due to decline in covered work.
    b. Increase in health care costs.
    c. Increase in utilization (perhaps due to decline in work).
    d. Inadvertent reserves due to favorable experience.
    e. Examples of fluctuations of this type from 10-year study of 500 plans.
3. Coverage for inactive participants.
    a. Extended and "underpaid" coverage due to eligibility rules.
    b. Extended coverage for "hour bank" employees, etc.

c. Retiree coverage.

D. Retiree coverage under multiemployer plans (Segal Company clients).

1. Almost 60% of the plans cover retirees, with variations. On average, retiree coverage adds about 11% to the per-employee plan costs, rising in some cases to almost 50%.

2. A reasonable proportion of those use various approaches to limited funding, although virtually none are attempting to pre-fund during the employees' working lifetimes.

E. Impact of DEFRA reserve limits.

1. If Multiemployer plans were held to the general rule, no economic contingency or extended coverage reserves would be allowed on a tax-exempt basis, and in 30-40% of the cases the deductibility of employer contributions would also be endangered.

2. Taxing the reserves increases the cost of the benefits they are intended to fund, perhaps to the point where they might not be affordable, especially since active workers' pay is, in effect, reduced by the amount of plan contributions.

3. Casting a cloud on the deductibility of negotiated contributions that employers are bound by the labor contracts to pay would create great bargaining pressure to minimize health plan contributions, to keep them at a level that is almost certain to be deductible -- and that might well endanger the plans' ability to pay currrent claims during a contract term.

4. If benefit cutbacks are necessary because of insufficient funds, for any of these reasons, continued coverage for those who are not currently generating plan contributions would become especially vulnerable.

5. If private sector retiree health benefits are curtailed, retirees will be forced

to rely on new or expanded government programs.

F. Special limits for collectively bargained plans under DEFRA.

1. Current law provides an opportunity for the Treasury to avoid these problems, by setting flexible reserve limits for collectively bargained plans.

2. In the DEFRA Technical Corrections Act, Congress could make sure that funding for benefits for retirees and others under multiemployer plans is not subject to these disincentives, by codifying the special limits for those plans rather than waiting for and relying on regulations.

III. The Search for Consistency in Health Plan Regulatory Initiatives

A. Developments increasing the cost of employer-funded health coverage.

1. Adverse tax treatment for funding, as noted above.

2. Medicare cutbacks (affects retiree coverage).

3. Change in Medicare coordination priority (affects older employee coverage).

4. Mandatory benefits under state law (affects insured plans, since the _Metropolitan Life_ decision).

5. Mandatory benefits under federal law (_e.g._, extended coverage for laid-off workers, surviving spouses, etc.)

6. Proposals to tax employees on the cost of employer-funded coverage (payroll taxes, "hold-harmless" pay increases).

7. Administrative complications and constraints (_e.g._, restraints on coordination of benefits, DEFRA requirement for actuarial certification for reserves, diluting incentives for cost control by undercutting individual group rating).

B. Developments increasing the need for funded retiree coverage.

1. Anticipated Financial Accounting Standards Board requirements.

2. Potential "vesting" in a right to post-retirement coverage.

3. Medicare cutbacks (including higher Part B premiums).

4. Freeze or cutbacks in Social Security and private pension benefits.

C. Combined impact.

1. What if active employees must give up more of their wages to help finance retiree coverage, and must then pay tax on the cost of that coverage? What if retirees must pay tax on the cost of their coverage?

2. If resources are diverted to funding future health care coverage, will enough be left to fund future retirement benefits? Current wages? Absent universal mandatory pension and health coverage, what will workers and employers choose?

D. Post-retirement cost-of-living supplements: a cautionary tale.

1. 1980 amendment to ERISA section 3(2)(B) enacted to facilitate and encourage inflation supplements for retirees by defining them as "welfare" benefits exempt from general ERISA vesting and funding requirements.

2. 1982 Labor Department Regulations, 29 C.F.R. section 2510.3-2(g), implement the Congressional directive and authorize use of a dedicated trust to fund the benefits.

3. To date, IRS has not allowed these benefits to be provided through a tax-exempt welfare plan's trust under section 501(c)(9) of the Internal Revenue Code.

4. Result: multiemployer groups, for which Taft-Hartley requires the use of a trust to hold contributions to fund benefits, cannot provide these simple and inexpensive cost-of-living supplements for their retirees.

WELFARE FUND ELIGIBILITY RULES

Fund/Industry	Welfare Eligibility
A. Manufacturing	Coverage continued for two months after month employment terminates.
B. Manufacturing	Coverage while working only.
C. Transportation	25 days in quarter for coverage in next quarter.
D. Transportation	200 day units in two calendar years.
E. Transportation	Coverage continued for one month after month employment terminates.
F. Construction	140 hours in quarter for coverage in next quarter. 1,900 hours in two calendar years -- one additional year.
G. Construction	210 hours in any six consecutive month period.
H. Entertainment	1,000 hours in year for coverage in next year.

I.	Entertainment	65 shifts in quarter for coverage next quarter.
J.	Service	30 days after termination of employment.

STATEMENT OF PHILIP BRIGGS, EXECUTIVE VICE PRESIDENT OF METROPOLITAN LIFE INSURANCE COMPANY BEFORE THE SENATE FINANCE COMMITTEE'S SUBCOMMITTEE ON SAVINGS, PENSIONS AND INVESTMENT POLICY

JULY 29, 1985

My name is Philip Briggs. I am the executive vice president of the Metropolitan Life Insurance Company in charge of Metropolitan's Group Life and Health Operations.

Metropolitan Life Insurance Company is a major insurer and administrator of employee health benefit plans and, as such, provides health benefits to over 14 million employees, retirees, and dependents. Our customer list includes many of the nation's largest employers as well as numerous medium-size and small employers. In addition, as an employer itself, Metropolitan provides health benefits to over 55,000 workers, including over 20,000 retired employees. Metropolitan is, therefore, vitally interested in and concerned over the issue for funding of the cost of post-retirement health benefits, and we wish to share our thoughts and recommendations with you today.

In our experience, many employers, particularly the larger ones, provide health benefits to their retired employees. In some cases the benefits are provided to retirees as a result of collective bargaining; in other cases, the benefits are provided voluntarily by the employer as a matter of prudent business practice or out of concern for the well being of workers who have provided long and faithful service to the employer.

Whatever the reasons or motivations for providing medical benefits coverage to retired employees, employers should recognize that these plans, once established, are likely to continue in operation indefinitely, and that over time they will give rise to a future liability which, if not properly funded over the working lives of the employees, ultimately can adversely affect the financial well being of the business enterprise.

In some cases, the obligation to provide retiree benefits is a legal obligation, and a number of recent court decisions have found such a legal obligation in situations where the employer contended there was none. However, even in the case where no legal obligation to continue the retiree health benefits appears to exist, there is generally a de facto obligation in that the employer reasonably cannot expect to be able to terminate the plan short of bankruptcy or other major fiscal calamity.

In Metropolitan's view, it is prudent fiscal policy and sound accounting practice for an employer to fund the cost of post-retirement pension, life insurance and health benefits over the active working lives of the employees involved. Such a funding practice permits the employer to properly match income and expenses, gives employees greater assurance that the benefits will be there when needed after retirement, and provides a much needed source of capital funds for the country as a whole.

While the need for funding of pension benefits for retirees has long been recognized by the business community, the same has not been true in the past for the funding of post-retirement welfare benefits, such as health benefits and group life insurance. Metropolitan, however, for over a quarter of a century has been a strong advocate of the funding of post-retirement life and health benefits, and we currently hold over 2.4 billion of retiree life and health benefit funds for large corporate employers. In the 1960's Metropolitan and its corporate customers played an instrumental role in convincing the Treasury and Congress that employers should be able to contribute actuarially determined amounts to fund post-retirement life and health benefits on a tax-deductible basis, and that the income credited to such funds should not be taxable. In addition to funding post-retirement health benefits through a fund held by an insurance company, an employer has had the option in the past of funding the benefits through a tax-exempt trust, such as a pension trust or a VEBA, with the same favorable tax treatment.

While many employers have been slow to fund post-retirement health benefits, it is our perception that there are a number of current factors which are pushing employers to seriously consider funding. One factor I previously mentioned is the trend in court decisions to find a legal liability for post-retirement medical coverage. Another is the study being made by the Financial Accounting Standards Board on the funding of post-retirement welfare benefits, which is likely to result in a requirement that the unfunded liability for such benefits must be reflected in the employer's financial statements. There is also the gradual recognition by many employers that the liability for unfunded welfare benefits for retirees is indeed enormous, in some cases far exceeding their unfunded pension liabilities.

From Congress' viewpoint, we believe that the funding of post-retirement health benefits is clearly in the national interest, and should be strongly encouraged. The health and well being of our senior citizens is a major national concern. However, in light of the deficit and budget problems the Congress is currently wrestling with, it is apparent that no significant expansion of the Medicare program is foreseeable. In fact, the converse is likely. Medicare's share of the cost of retiree health medical benefits can be expected to decrease, with more of the cost shifted to the private sector. Therefore, it is in the public interest to actively foster the growth and fiscal soundness of employer-provided health benefits for retirees. If the private sector fails to meet the pressing social need, the burden eventually will fall back on the federal and state governments under programs such as Medicare and Medicaid, at an ultimate cost to the public that will more than offset the cost of encouraging private sector coverage through tax incentives.

Regrettably, two of the provisions in the Deficit Reduction Act of 1984 severely discourage the adequate funding of post-retirement health benefits. There was no real opportunity for hearings or other input from interested parties on these provisions. Under the first provision, the income on post-retirement health benefits funds will be subject to current income tax starting in 1986. If the fund is held by a VEBA the VEBA will pay the tax at corporate rates. If the fund is held by an insurance company, the employer will be required to pay the tax. The second adverse provision in the 1984 law states that in establishing and funding a post retirement health benefits fund, the employer cannot assume any increase in medical costs in the future. While there are encouraging signs that cost control measures in the health benefits field are now working to restrain the growth of medical benefits costs, a funding assumption of zero growth in medical costs in not an actuarially sound approach to the funding of post-retirement medical benefits.

Congress in DEFRA directed the Secretary of the Treasury to study and report on possible means of providing minimum standards for welfare benefits plans in the areas of participation, vesting, accrual and funding of benefits for both active and retired employees. Metropolitan recognizes that reasonable standards may be desirable to ensure that retirees receive the medical benefits they expect, and that it may be desirable to condition favorable tax treatment on compliance with such reasonable standards. However, we believe that the tax on the income from retiree medical reserves is bad public policy and should be eliminated as quickly as possible. It should not have to await the imposition of minimum standards for welfare plans, which may take a considerable amount of time to develop and implement legislatively.

It should be noted that DEFRA did impose significant safeguards against abuse in the funding of post-retirement medical benefits on a tax-deductible basis. Thus, tax-deductible funding is allowed only where the medical benefits plan does not discriminate in favor of the highly compensated. Also, the imposition of a 100 percent excise tax on any reversion to the employer precludes diversion of the fund for other purposes.

I urge the members of this Subcommittee to seek a prompt legislative reversal of the decisions made in DEFRA to tax the investment income on post-retirement medical benefit reserves, and to limit the funding to an actuarially inadequate amount. Encouragement of the funding of retiree medical benefits clearly is in the public interest, and I firmly believe that funding of retiree medical benefits is entitled to the same tax treatment as the funding of post-retirement pension and group term life insurance benefits.

STATEMENT OF ROBERT MAXWELL, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, CROSSVILLE, TN

Mr. **Maxwell.** Mr. Chairman, we want to thank you very much for the opportunity to be here. Our President, Vita Ostrander, would very much like to have been here but was committed to something in California this week and regrets that she can't be here. She sent me to speak for her.

We have long, as an association, been concerned about access to quality health care, not just for retired persons but for young and old alike. Unfortunately, access to quality health care is a growing problem in our county, and it affects patients of all ages. It is a problem in all regions of the country. Access to quality health care is a national problem.

An important factor affecting this problem is the loss of employer sponsored postretirement health care benefits by thousands of retired persons. The loss of these benefits occurs because of plant closings, mergers, sale of employer company, and so forth. Stopping the loss of these benefits is going to require national policies to encourage employers to fulfill their important role in making high quality health care services available to retired persons.

Our extended testimony focuses on some of the reasons that we believe that a strong employer sponsored postretirement health care system of programs is vital to our overall health care financing system.

Because of our time constraints, I would like to go to some of the basic principles of reform that we think are necessary.

Senator **Heinz.** Without objection, Mr. Maxwell, your entire statement will be a part of the record.

Mr. **Maxwell.** Very good, sir.

There are a number of forces that contribute to the loss of employer sponsored health care benefits, because the situation seems to keep reforming. Medical inflation and cutbacks in Medicare are examples of reasons why employer sponsored postretirement health care benefits should be maintained and examples of basic areas to reform.

Reducing the high rate of medical inflation will make it easier for employers to keep up their postretirement obligations. A stable Medicare Program is essential for employers to know what they are covering, without worrying that cuts in Medicare will result in new unforeseen health care liabilities. This is a necessary prerequisite to maintaining a reliable employer-sponsored program of postretirement health care benefits in a stable and predictable Medicare Program.

Medicare must be the foundation upon which employer sponsored postretirement health care benefits are based. Such postretirement benefits can never develop if employers are always unsure of the role Medicare will play in meeting postretirement health care needs.

There are more subtle issues of how to assure that health benefits will be there at the time of retirement and through retirement. It is this question that we think is at the heart of the hearing today.

Ten years ago we faced a similar situation when employers abused retirement pensions. Congress responded by providing a framework and a mechanism for securing basic pension rights. Today, reliable health care benefits in retirement are as important as a reliable pension.

Congress must seriously consider, therefore, securing reliable postretirement health care benefits.

Despite the difficulty of developing formal mechanisms to ensure that employer-sponsored postretirement health benefit promises will be kept, AARP firmly believes that such mechanisms must be developed and implemented.

Perhaps the least intrusive approach to providing some assurance that benefits will be there at retirement is to forbid employers from asserting termination rights that are not disclosed in descriptions of employee or retiree benefits. Administering this type of regulation is relatively simple, because enforcement is through private action; therefore, it does not require an extensive bureaucracy.

As the Congress and other policy thinkers consider formal protection mechanisms, there are initiatives that can be taken now to encourage employers to provide postretirement health benefits. These initiatives are aimed at removing statutory incentives that tend to frustrate the development of greater employer involvement in postretirement health benefits:

First, we think that we should modify ERISA provisions that preempt State law, so that the strong incentive for employers to self-insure is neutralized.

Second, we need to re-evaluate the Deficit Reduction Act of 1984, incentives to not fund postretirement benefits.

May I just finish these two?

Senator Heinz. Please proceed. You are doing fine.

Mr. Maxwell. All right, sir.

The Deficit Reduction Act provided a series of incentives that discourage employers from funding postretirement health benefits. They are: First, future health care inflation costs not be considered in allowing setting the amount to be funded; which means that the benefit at retirement will be seriously underfunded.

Second, funding must be no more rapid than on a level basis over the working lives of participants. This means that employers must fully fund the postretirement benefit before retirement.

And, third, taxing the earnings on the benefit investment takes away the tax-free accumulation of funds targeted for postretirement benefits, and is a major disincentive to prefunding such benefits.

I would like to emphasize again that solving the issues that discourage employers from providing postretirement health benefits is but one piece of the puzzle, although a very important piece. Our task is to fashion a comprehensive national health care policy through the coordination of various health care policies. Thus, we seek to address these serious issues. Let us be mindful of the impact our decisions have on the development of a comprehensive health care delivery system.

I want to thank you Senator, for allowing an association of ours to come and give testimony in your hearing. We sincerely appreciate it.

Senator **Heinz**. Mr. Maxwell, thank you for being here. Please convey our warmest regards to Vita Ostrander, who has appeared before the Aging Committee, to my certain knowledge, on many occasions. I don't know whether she has appeared before the Finance Committee before, but knowing Vita I suspect there isn't much she hasn't done.

Mr. **Maxwell**. That's true.

[Mr. Maxwell's written testimony follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

EMPLOYER-SPONSORED POST RETIREMENT HEALTH CARE BENEFITS

before the

SENATE FINANCE COMMITTEE

SUBCOMMITTEE ON SAVINGS, PENSIONS & INVESTMENT POLICY

July 29, 1985

Presented by:

Vita Ostrander
President

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

Thank you, Mr. Chairman. My name is Vita Ostrander and I am President of the American Association of Retired Persons. On behalf of the 19.3 million members of AARP, I want to thank you for this opportunity to offer a consumer perspective on the difficult problem of securing reliable health care benefits for our country's retired work force.

My Association has long been concerned about access to quality health care, not just for retired persons, but for young and old alike. Unfortunately, access to quality health care is a growing problem in our country; it effects patients of all ages and it is a problem in all regions of the country. Access to quality health care is a national problem.

An important factor affecting this problem is the loss of employer-sponsored, post retirement health care benefits by thousands of retired persons. The loss of these benefits occurs because of plant closings, mergers or sale of the employer company. Stopping the loss of these benefits will require national policies to encourage employers to fulfill their important role in making high quality health care services available to retired persons.

My testimony today will focus on the reasons the Association believes strong, employer-sponsored post retirement health care programs are vital components of our health care financing system. I will end by suggesting some basic principles for addressing the loss of these benefits.

EMPLOYER-SPONSORED POST RETIREMENT HEALTH CARE PROGRAMS ARE ESSENTIAL

Several trends underlie the need to maintain a broad based approach to assuring access to quality health care for retired persons. These trends include a growing aged population, high out-of-pocket costs for health care, cuts in Medicare and Medicaid, and large, looming costs for long term care.

A Growing Aged Population

The rapid growth of the age 65 and older population requires greater employer involvement in post retirement health care benefit programs. Today only 11 percent of the population is age 65 or older, yet older persons account for nearly 30 percent of the nation's total personal health care expenditures. By the year 2015, over 18 percent of the population will be age 65 or older -- a significant increase with obvious implications for health expenditures.

Within the elderly population, the age 75 and older subgroup is increasing most rapidly. By the year 2000, 45 percent of the elderly population will be in this category, compared to less than 40 percent now. The proportion of older persons who are age 75 and older is important because the incidence of chronic disease and impairment and the utilization of medical services tends to increase with age, and increase dramitically after age 75. Employer-sponsored post retirement health care benefits will be necessary to help finance needed care for our aging population.

High Out-of-Pocket Costs

Older persons pay a substantial portion of their health care bills directly out-of-pocket. Out-of-pocket payments borne by Medicare beneficiaries for health care have outpaced the growth in their incomes. As a result older persons have been spending an increasing share of their mean per capita income to meet their health care needs.

Persons aged 65 and over paid roughly $700 out-of-pocket per capita for medical expenses in 1977. By 1984, this amount increased by over 120 percent to $1550 per capita, equalling 15 percent of the annual mean per capita income of the aged ($10,615), the same percentage that the elderly paid for health care before Medicare was implemented. Assuming no further cutbacks in Medicare are enacted, by the year 2000 almost 20 percent of elderly per capita income is projected to be consumed by health care expenditures.

Of course, it is not realistic to assume that no further cutbacks in Medicare will be enacted. The House and Senate budget resolutions for FY 1986 both include substantial cuts in the Medicare program. Employer-sponsored health benefits for retirees must play a larger role in alleviating the burden of high out-of-pocket costs.

Cuts in the Medicare Program

The most important health care program serving the elderly is Medicare. There is no doubt that the enactment of Medicare greatly increased access to health care for older persons. Continued high rates of health care inflation, however, threaten to defeat the access initially gained.

Because Medicare is patterned after the structure of the health care industry in general, rapid escalation in health care costs, particularly hospital costs, have driven up the costs of Medicare. With nearly three-quarters of Medicare expenditures spent on hospital care, rising hospital costs, combined with other adverse economic circumstances, are taking their toll on the Hospital Insurance (HI) Trust Fund (Part A), the main Social Security trust fund financing Medicare. The HI Fund's Trustees project that the fund's reserves will be exhausted in the 1990s and that it will never regain solvency over the entire twenty-five year projection period.

Anxious to reduce the rate of increase in spending for Medicare, Congress and the Administration have drastically cut Medicare expenditures over the past four fiscal years, cutting $35 billion through FY 1987 (not counting cuts resulting from the FY 1986 budget). The incremental reduction of Medicare through higher premiums, deductibles and similar measures that merely shift costs to beneficiaries does not address the underlying problems in the program and therefore has little impact on the escalation of costs in Medicare or in the health care sector. And as Medicare's costs have risen, Medicare's contribution, as a percentage of the total health care expenditures of older persons, has fallen; now equalling only 45 percent. The sad reality is that the higher the cost of Medicare, the less beneficiaries are getting from it. Continued erosion of employer-sponsored post retirement health benefits only makes a bad situation worse.

Looming Long-Term Care Needs

The growing need for long-term care (LTC) services will strain older persons, Medicare and Medicaid alike. Americans are living longer (since 1960, over two years of life have been added to the life expectancy of the average 65 year old American). Millions of lives have been saved from acute heart attacks, strokes, early death from cancer, diabetes and other acute conditions. The more successful, however, the nation's health system has been at controlling acute disease and postponing death, the more that chronic disease has tended to become the dominant pattern of illness. By definition, chronic disease is never cured.

Because of the aging of the population and chronic disease as the dominant pattern of illness, demand for long-term care services is increasing. Yet, current demand is not even being met. There are an estimated 3.5 million non-institutionalized persons age 65 and over who are "functionally dependent," and their numbers are increasing by about 100,000 a year. Fifteen years from now, in the year 2000, there may be well over five million persons in this category. Approximately thirty percent of these functionally dependent older persons are homebound or bedridden. A still larger proportion are alone and isolated. Another 1.3 million older persons are in nursing homes, chronic care hospitals, or other institutions. Addressing the continuum of LTC services necessary to meet this growing need will require resources from a variety of sources. Employer-sponsored post retirement health benefits must contribute to the solution of this awesome public policy challenge.

The four trends identified above underscore the need to maintain a broad-based system for financing health care services to the retired population. Medicare and Medicaid alone cannot provide the access to care necessary to meet the needs of our people. Thus, it is important that public policy encourage, to the extend possible, that employers provide post retirement health care benefits.

BASIC PRINCIPLES FOR REFORM

Since there are a variety of forces contributing to the loss of employer-sponsored post retirement health care benefits, reforming the situation requires a variety of solutions. Medical inflation, and cutbacks in Medicare are examples of both reasons why employer-sponsored post retirement health care benefits should be maintained and examples of basic areas to reform.

Reducing the high rate of medical inflation will make it easier for employers to keep up their post retirement obligations. Similarly, a stable Medicare program is essential for employers to know what they are covering without worrying that cuts in Medicare will result in new, unforeseen health care liabilities. Thus, a necessary prerequisite to maintaining a reliable employer-sponsored program of post retirement health care benefits is a stable and predictable Medicare program. Medicare must be the foundation upon which employer-sponsored post retirement health care benefits are based. Such post-retirement benefits can never develop if employers are always unsure of the role Medicare will play in meeting post retirement health care needs.

Beyond these basic issues, however, are the more subtle issues of how to assure that health benefits will be there at the time of retirement and through retirement? It is this question that is at the heart of the hearing today.

Ten years ago we faced a similar situation when employers abused retirement pensions. Congress responded by providing a framework and mechanism for securing basic pension rights. Today reliable health care benefits in retirement are as important as a reliable pension. Congress must seriously consider, therefore, securing reliable post-retirement health care benefits.

Despite the difficulty of developing formal mechanisms to assure that employer-sponsored post retirement health benefit promises will be kept, AARP firmly believes that such mechanisms must be developed and implemented. Perhaps the least intrusive approach to providing some assurance that benefits will be there at retirement is to forbid employers from asserting termination rights that are not disclosed in descriptions of employee/retiree benefits. Administering this type of regulation is relatively simple because enforcement is through private action and, therefore, does not require an extensive bureaucracy.

A more intrusive approach to securing employer-sponsored post retirement health care benefits is to establish formal protections for health benefits. Establishing these protections, however, is difficult because of the nature of the benefit involved. Is the benefit an amount of cash as in the pension area, or access to health care *services*? While a cash benefit would be easier to work with, over time it is unlikely to provide sufficient buying power for the kind of services needed by retirees.

Defining eligible participants and developing vesting and benefit accrual rules must be done before it is possible to wrestle with funding the benefit. It is obviously essential to know the scope of the right requiring funding. If the funding requirements are too stiff, employers might be discouraged from providing any post retirement health benefits whatsoever.

Providing formal protections for post retirement health benefits requires a great deal more study and analysis. Formal protection mechanisms will effect our entire socio-economic system and, therefore, deserves the most careful deliberation.

As the Congress and other public policy thinkers consider formal protection mechanisms, there are initiatives that can be taken now to encourage employers to provide post retirement health benefits. These initiatives are aimed at removing statutory incentives that tend to frustrate the development of greater employer involvement in post retirement health benefits.

1. Modify the ERISA provisions that preempt state laws so that the strong incentive for employers to self-insure is neutralized.
2. Reevaluate the Deficit Reduction Act of 1984 incentives to NOT fund post retirement benefits. The Deficit Reduction Act of 1984 provided a series of incentives that discourage employers from funding post retirement health benefits. They are:
    a. Future health care inflation costs to be considered in not allowing setting the amount to be funded, means that the benefit at retirement will be seriously underfunded.

b. Funding must be no more rapid than on a level basis over the working lives of participants. This means employers must fully fund the post retirement benefit before retirement.

c. Taxing the earnings on the benefit investment takes away the tax free accumulation of funds targeted for post retirement benefits, and is a major disincentive to prefunding such benefits.

Finally, Mr. Chairman, I would like to emphasize again that solving the issues that discourage employers from providing post retirement health benefits is but one piece of the puzzle, albeit an important piece. Our task is to fashion a comprehensive national health care policy through the coordination of various health care policies. Thus, as we seek to address these serious issues let us be mindful of the impact our decisions have on the development of a comprehensive health care delivery system.

Thank you.

Senator HEINZ. Let me ask Ms. Mazo—you said in your testimony that multiemployer plans do not prefund retiree health benefits now. Is most of the funding terminal funding?

Ms. MAZO. It is a variety of terminal funding, yes, to the extent that they are able to afford it.

Senator HEINZ. Are the reserve limits in DEFRA sufficient for this kind of funding?

Ms. MAZO. Absolutely not. There are two answers to that Senator. The reserve limits in DEFRA that apply to plans other than collectively-bargained plans would be inadequate to maintain stability even for active workers under multiemployer plans. However, DEFRA does authorize the Treasury to set special limits for plans that are maintained pursuant to collective bargaining agreements. We are trying to persuade the Treasury—and I don't mean to imply that they are being uncooperative—that those limits should be flexible enough to take in the particular problem of really a whole group of benefit plans living on a fixed income, if you will.

One thing. If this committee gets to the DEFRA Technical Corrections Act, you could make the Treasury's job easier by just codifying the exemption that they are trying to figure out a basis for giving us in regulations.

Senator HEINZ. Yes; we have been talking about that Technical Corrections Act now for 7 or 8 months. We may actually get around to it one of these days.

Ms. MAZO. Well, if DEFRA is any example of what happens when there were TEFRA technical corrections enacted, I guess that whatever next big tax bill we see may include some of these other technical things too.

But the DEFRA reserve limits would be completely unacceptable, because they only allow reserves for what multiemployer groups don't even think of as reserves. That is, they would only authorize on a tax-free basis the reserves for incurred but unreported claims. They would allow prefunding for retiree coverage only on a taxable basis.

There is also the issue of potential challenge to employer tax deductions. And we estimate that probably a third of the multiemployer plans, even those with large numbers of contributing employers, might run afoul of the deduction limits if they had to face them directly; which means clearly you would have a very destabilizing influence on the plans, because employers will negotiate to pay this compensation in a form that is obviously deductible rather than in some form where there may be some question of whether or not there is appropriate tax treatment.

Senator HEINZ. What problems does the mandatory prefunding requirement present to multiemployer plans?

Ms. MAZO. The principal problem is that they may have terrific difficulty maintaining the current benefit package at the existing negotiated contribution levels, if at the same time they would have to start reserving at present for the active employees. In other words, the short answer is: Right now, many of them would not be in a position to afford it.

In the past I asked a number of my colleagues and associates about patterns of bargaining contribution rates over the past 4 or 5 years. And whereas, around 1980, it used to be a general rule that the pension contribution and the welfare plan contribution were roughly equal, for the past 5 years virtually all the benefit fund increases have been on the welfare side; and even in industries where there have had to be negotiated givebacks on wages, just to maintain the basic hospitalization and major medical packages, given health care inflation, they have had to devote whatever funds they could negotiate from the industries to maintaining the existing health plans for all of them.

So having at this point to earmark a big chunk of that money for prefunding the retirement coverage for current workers, while it would be extremely desirable from a theoretical point of view—as I said, it is something we would all like to be able to encourage them to do—I don't know if many of them could afford it.

There is also a question that some people have raised, a philosophical question, which comes up in multiemployer cases. You have a very clear relationship between the amount spent on benefits and the amount spent on wages, because you typically will have a negotiated package. The employers may offer, let's say, "Well, we can afford an additional $4 an hour this time; how much do you want in pension? How much do you want in welfare? And the rest will go in wages." Active employees recognize directly the relationship between what they are receiving in their pay package and what is going in to finance the benefit plan. But the question has been raised: Why should the retirees have more benefit security than the current active population who are working to generate the funds to finance it?

I can't tell you that the National Coordinating Committee would say that they shouldn't or that they should, or that that would be the natural relationship; but there might be some additional tension there in terms of mandatory funding for health coverage.

Senator **Heinz**. All right. Let me ask Mr. Maxwell a question. You talked in your statement about the need for benefit protection in the form of vesting and benefit accruals rules. How can we go about vesting health benefits?

Mr. **Maxwell**. Well, it would seem to me that there is very little difference between handling them as we handled the pension program under ERISA, that certainly we can accumulate I guess you would call it a prepayment basis for post-retirement expense.

One of the things that I as an insurance man am concerned about is this idea of taxing the accumulations that are accrued for the protection of our employees in their retirement. It just seems to me that we are sort of kicking the people that are feeding the retirement system by taxing the income on their accrual. And to me, this is a whole new concept of Government.

Senator **Heinz**. You are talking about, in part, the taxation of whole like, the inside buildup?

Mr. **Maxwell**. Right. And I presume that we are talking here about taxing the investment income from accruals for paying for retirement.

Senator **Heinz**. Well, that is the same principle that operates in DEFRA on VEBA's. That's right.

Mr. **Maxwell**. This is a disincentive. There is no question about that. A disincentive as far as the employer is concerned.

Senator HEINZ. Let us assume for a moment that we solved those problems. Do you feel that we need a benefit guarantee similar to the pension guarantee to protect the benefits of workers for those firms that go out of business?

Mr. MAXWELL. I think that we as an association definitely feel that way. There should be, as with Social Security, some minimum which people can plan for their retirement.

Senator HEINZ. Now, that brings us back to the kind of benefit that we are talking about here.

We received a lot of testimony earlier that said, "Well, if you are going to guarantee things, you can't, given so much of the uncertainty in this health area, guarantee specific health benefits; you either have got to have a defined contribution or a defined dollar benefit." Do you agree with that?

Mr. MAXWELL. I agree with that, because I can envision a volume of things that say, "These are the things that we are going to pay for regardless of the cost." That would be disastrous to the program, in my opinion. I think we need to set some kind of a financial limit.

Hopefully, if the cost of Medicare continues to spiral as it has, the financial money cost of those things can be adjusted in the retirement planning.

But this is another point I definitely want to make: We think that in projecting the accruals to pay for retirement that we should take into consideration the fact that costs are going to be higher in the future.

Senator HEINZ. That what?

Mr. MAXWELL. That costs are going to be higher in the future. We should not make a formula for accumulating the savings to pay for retirement on the basis of today's costs.

Senator HEINZ. Well, I think we have pretty well covered the waterfront here, unless there is anything you would like to add.

Ms. Mazo.

Ms. MAZO. I would like to underscore Mr. Maxwell's comments that one of the most important things that Congress can do, to the extent it is within Congress' power to do it, is to take creative approaches to trying to tamp down medical care inflation, particularly through creative approaches in Medicare and other systems through which the Federal Government is a purchaser.

In addition to that, I think perhaps give employers a respite in terms of adding to the costs that they have to pay for. Mandatory benefits added into plans, each of which might not cause too much on its own, would divert money.

For instance, there will be hearings next week on a proposal to mandate pediatric preventive care. That may be a nice package of benefits to provide; but, if you are going to direct that plans include coverage for that, you have to ask yourself whether it is reasonable also to direct them to start earmarking for retirees as well. And once you have paid for all of that, what is left for the wages and retirement benefits?

Senator HEINZ. Mr. Maxwell, is there anything else you would like to add?

Mr. MAXWELL. No; but I appreciate your letting us come and voice our concerns.

Senator **Heinz**. I think it has been a very helpful and productive hearing. I think we have gotten pretty close to a consensus that there are a variety of difficulties and uncertainties, from the standpoints of both tax policy and assuring that retirement health protections aren't going to be inadvertently misappropriated. We have heard that there are some better and some worse ways of ensuring the availability of those benefits, that there are some relatively more practical and less practical ways of tying those into a package, depending upon the kind of benefits you are talking about.

You made this point, Mr. Maxwell, repeatedly, but you were not alone in making the point, that since Medicare is the big enchilada in retirement, that whatever it is that is happening to Medicare or with Medicare is of paramount importance if employers are to be encouraged in any way to take a more active role than they have heretofore in providing these retirement health care benefits. And that needs to be emphasized and reemphasized.

So I want to thank all of you, including all of our witnesses who have been keeping an eye on things today. We thank you very much and appreciate your participation.

The hearing is adjourned.

[Whereupon, at 5:03 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT TO THE SENATE SUBCOMMITTEE ON SAVINGS, PENSIONS AND INVESTMENT POLICY ON BEHALF OF THE SUBCOMMITTEE ON HEALTH AND WELFARE PLANS OF THE AMERICAN ACADEMY OF ACTUARIES

HEARINGS ON FUNDING RETIREE MEDICAL BENEFIT PLANS

September 9, 1985

On September 9, the Senate Finance Committee's Subcommittee on Savings, Pensions and Investments held hearings to examine the problems encountered by employers in funding retiree medical benefits. The comments below are submitted for the record of those hearings.

PURPOSE

The American Academy of Actuaries (the Academy) appreciates the opportunity to submit comments regarding the difficulties encountered by employers in funding retiree medical benefits. This document discusses funding post-employment benefits from an actuarial perspective and comments on two vehicles available for tax preferred funding of retiree medical benefits: voluntary employee beneficiary associations (also known as VEBAs and 501(c)(9) trusts) and qualified pension trusts. The tax advantages associated with funding these benefits through VEBAs were limited by the 1984 tax act while similar limitations were not placed on funding through qualified pension trusts. Members of the actuarial professional have been instrumental in the researching and determination of the implications of employers' guarantees of medical coverage into retirement. The Subcommittee on Health and Welfare Plans of the Academy (the Subcommittee) has in the past year engaged in education presentations on the subject for the IRS Employee Benefit Section, the Department of Labor, and FASB. We welcome this opportunity to comment upon a topic which will become increasingly important in the years to come.

BACKGROUND

The American Academy of Actuaries is a professional association of over 7,600 actuaries involved in all areas of specialization within the actuarial profession. Included within our membership are approximately 85% of the enrolled actuaries certified under the Employee Retirement Income Security Act of 1974 (ERISA) as well as comparable percentages of actuaries specializing in actuarial services for other employee coverages such as life, health and disability programs. As a national organization of actuaries, the academy is unique in that its members have expertise in all areas of actuarial specialization.

The Academy does not advocate any major public policy decision such as tax legislation, which is not actuarial in nature. The Academy views its role in the government relations arena as providing information and actuarial analysis to public policy decision-makers, so that policy decisions can be made with informed judgment. It is our belief that the training and experience of Academy members allow a unique understanding of current practices in employee benefits. Our intention is to communicate that understanding in ways that assist policy decision-makers.

ADVANCE FUNDING

The Academy believes that it is advisable for employers to fund their retiree medical benefits in a manner which assures payment of promised benefits. For most employers this will mean funding benefits on a level basis over the working careers of their employees. This type of funding of accrued post-employment benefits - whether from a pension plan, a retiree medical benefit plan, or a retiree life insurance plan - is commonly referred to as "advance funding". When retiree medical benefits are funded in advance, the plan's trust will hold assets estimated to be sufficient to fully fund the benefits for all current retirees, as well as a portion of the assets estimated to be needed to fully fund the projected benefits of current employees once they retire. Only when retiree medical benefits are funded in trust on this basis (or a more accelerated basis) can employees be confident they will receive the medical benefits promised for their retirement.

The estimated contributions to advance fund a retiree medical plan can be calculated by an actuary experienced in retiree medical plans issues, using reasonable actuarial assumptions and methods. Actuaries have given increasing attention in recent years to the assumptions and estimation methods appropriate for the valuation and funding of retiree medical plans. The main reason for this attention is the magnitude of the liability associated with such plans. Actuarial studies for employers who have both pension and medical plans have most often placed the liability for the retiree medical benefits at between 50% and 100% of the pension liability.

VEBAs

The changes in tax law made by the Deficit Reduction Act of 1984 (DEFRA) substantially discourage employers from advance funding their retiree medical benefits through a VEBA. First, DEFRA has greatly reduced the tax deductions permitted employers for contributions to a VEBA to advance fund retiree medical benefits. In the calculation of the deduction limit, DEFRA no longer permits employers to provide for expected future medical care cost inflation in their calculations (see IRC Section 419(c)(2)(A) and the Conference Committee Report on the Section). As actuaries who have studied the matter, we believe that the exclusion of an assumption for future inflation is unrealistic and substantially understates future costs and liabilities. This is increasingly true if "inflation" is interpreted to include increased utilization of medical services independent of price increases, or to include changes in Medicare reimbursement or medical technology. These factors all will effect an employer's future payments for retiree medical benefits.

This change by DEFRA has two significant results.

- It has reduced the maximum tax deductible contribution to a VEBA by a considerable amount. Reductions of two-thirds or more can often be expected.

- With the limited tax deductions, an employer can never accumulate sufficient assets on a tax effective basis to fully fund benefit promises at the time of retirement if there is a later medical care cost inflation. Post retirement medical inflation will require additional contributions for retiree medical benefits after an employee retires. (Please note that this runs contrary to Congressional intent for pension plans in ERISA. One of the primary goals of ERISA was to require employers to accumulate assets sufficient to fully fund the employee's pension when that employee retires.)

DEFRA also has taken away one of the greatest incentives for employers to fund retiree medical benefits through a VEBA: The tax-free accumulation of investment earnings on contributions. If an employe accumulates in an VEBA assets which exceed more than about four months' claim payments and expenses, the investment earnings on those excess assets are generally subject to tax as unrelated business income. Furthermore, investment earnings on any advance funding of retiree medical benefits will result in an unrelated business income tax (see IRC Section 512(a)(3)(E)). This tax discourages many employers from advance funding their retiree medical benefits, which in turn reduces the financial security of covered retirees and dependents.

Finally, DEFRA added the requirement of separate accounts for key employees. The inclusion of retiree medical contributions made on behalf of key employees in the defined contribution limitation of Internal Revenue Code Section 415(c) substantially discourages employers from advance funding their retiree medical programs (see IRC Section 419A(d)). There are at least two reasons why. The first is that the determination and administration of the separate accounts presents another cost to the employer. A second reason is that executives who make the decisions as to whether or not to advance fund may be influenced by personal disadvantages involved in advanced funding. For instance, if an employer with a chief executive officer having qualified retirement benefits at or just below the Section 415 limitations were to advance fund retiree medical benefits, the funding of retiree medical benefits would reduce the qualified retirement benefits which the chief executive officer would receive. If no advance funding of retiree medical benefits occurs, the chief executive officer would not have his qualified retirement benefits reduced, and may still receive the medical benefit in retirement. Since it can be in the best interests of chief executive officers not to advance fund retiree medical benefits, many employers may not do so.

The alterations in the tax code have led in the last year to an interest on the part of many employers in the use of qualified pension trusts for the funding of retiree medical benefits.

QUALIFIED PENSION TRUSTS

Under Internal Revenue Code Section 401(h), employers are also permitted to fund retiree medical benefits through a qualified pension trust. The funding of retiree medical benefits through qualified pension trusts removes many of the difficulties described above for VEBAs:

- For the purpose of determining the maximum tax deductible contribution, it appears that the Internal Revenue Code regulations permit employers to recognize future medical care cost inflation.

- Investment earnings on retiree medical contributions made to a qualified pension trust are not subject to tax.

- Contributions made to a qualified pension trust on behalf of most key employees are not counted against the Section 415 limitation on qualified pension benefits. The only employees who are subject to this limitation are 5% owners (see IRS Section 401([illegible])(6)).

However, employers are confronted with other difficulties in funding their retiree medical benefits through a pension trust:

- Under Internal Revenue Code regulations, it appears that contributions for the current service costs of retiree medical benefits cannot exceed 25% of the aggregate contributions made to a pension trust for the current service costs. (See IR Regulation Section 1.401-14(1). This restriction results from the requirement that non-pension benefits be "incidental" in a pension plan.) Contributions at this level are often not sufficient to fully fund an employee's retiree medical benefit at retirement.

- If an employer sponsors a pension plan and either a profit sharing plan or a stock bonus plan, the aggregate tax deductible contribution to all qualified retirement plans (pension, profit sharing and stock bonus), including the contribution for retiree medical benefits made to the pension trust, cannot exceed 25% of the compensation paid by the employer to its employees. When an employer is making this maximum 25% of compensation contribution already to qualified retirement plans, the absence of a tax deduction for additional contributions for retiree medical benefits generally will stop it from funding retiree medical benefits through a pension trust.

Nevetheless, despite these drawbacks, dissatisfaction with the DEFRA limitations on the use of VEBAs for advance funding of retiree medical benefits has caused many large employers who would like to act in the best interest of their employees to investigate qualified pension trusts.

CONCLUSION

It is our understanding that among the reasons for the 1984 tax amendments affecting VEBAs were the following suspected ramifications of leaving the code as it was:

- Abuse (inflation assumptions would be overstated to exaggerate deductions)
- Large deductions (even stated accurately, liabilities would prove to be so large that a considerable tax expenditure would result)
- Additional tax incentives for health care (some economists feel health care inflation is partially a result of tax preferences)
- Key employees would be the main beneficiaries of the tax preferences.

While these may or may not be legitimate problems, we feel there must also be an awareness that the DEFRA changes did not enhance the financial security of retiree medical plan participants.

The DEFRA restrictions on advance funding came at a time when other segments of our society were turning attention to retiree medical benefits. The accounting profession has begun to require more financial reporting for retiree medical plans. Recent court cases have further secured the rights of retirees to receive these benefits from employers. These factors formalize and legitimize retiree medical benefits while provisions in DEFRA (in direct contradiction to incentives applied to today's pension plans) have removed tax advantages and confused the legal framework of advance funding.

Converging factors of tax limitations, court mandates requiring permanence of retiree plans, potential Financial Accounting Standards Board expense standards and rising costs are making this employee benefit financially hazardous to any employer offering it. As a result, these benefits are not being initiated as often as in the past and cutbacks or discontinuations are being contemplated by some employers. While the 1984 tax limitations are not the only reason for this change in attitude, these limitations have been a significant factor in the last year among those making these decisions or contemplating their implications.

The actuarial profession, as represented by the American Academy of Actuaries appreciates the opportunity to present our testimony and wishes to offer any possible assistance to the governmental bodies involved in studying welfare benefit plans. Because we understand past and present practices in this area, we believe that we can assist in identifying and weighing the merits of employee benefit plan alternatives for the future. We hope the comments presented in this statement will be useful in helping the Senate to deal appropriately with the complex area of retiree medical plans.

STATEMENT
OF
ÆTNA LIFE & CASUALTY
ON THE SUBJECT
OF
RETIREE HEALTH BENEFITS

SUBMITTED TO

SUBCOMMITTEE ON SAVINGS, PENSIONS AND INVESTMENT POLICY

COMMITTEE ON FINANCE

UNITED STATES SENATE

HEARING: SEPTEMBER 9, 1985

SUBMITTED BY

BURTON E. BURTON
PRESIDENT, EMPLOYEE BENEFITS DIVISION

FUNDING OF RETIREE HEALTH BENEFITS

Ætna Life Insurance Company is a leading insurance company provider of group health benefits, with 1984 health benefit payments totaling $6.7 billion. We have over 50,000 employer customers who are pension and welfare benefit plan sponsors. We insure or administer benefits for more than 12,000,000 employees and dependents under plans providing life and health insurance. In addition, we are a major plan sponsor for about 87,000 of our own employees, retirees and their dependents nationwide.

We understand the importance of provision by the private sector of health benefits for the growing population of retirees, and we welcome this opportunity to share with the Subcommittee our views on the problems encountered by employers in funding of such benefits. In particular, we will focus our comments on the current and future implications of the Deficit Reduction Act of 1984 (DEFRA) for the funding of retiree benefits. We believe these implications are serious and may negatively impact the continued availability and growth of private sector health benefits for retirees.

Scope of The Problem

Employer-provided retiree health benefits are a widely offered benefit, particularly by larger employers. Several recent surveys have found that such benefits are offered by more than 90 percent of large employers. Department of Labor data indicate that in 1984, 57 percent of all regular full-time workers in medium and large companies were covered for retiree health benefits.

While estimates of employers' total liability for providing health benefits to today's retirees and future retirees range from several hundred billion dollars to between $1 and $2 trillion, there is no doubt that these costs are large and growing. Among the reasons for these increasing costs are: health care inflation, the growing number of older adults, the concommitant increase in health care utilization accompanying old age, and cutbacks in public benefits under Medicare.

Employers are just beginning to understand their liabilities for these benefits and very few have yet taken the step of establishing a means to pre-fund their obligations. A recently completed survey by the Washington Business Group on Health found that only 5 percent of the companies offering retiree health coverage now pre-fund these obligations.

Several factors, however, are now converging to initiate growing interest in the pre-funding of these benefits. First, recent court decisions dealing with employer and employee rights and obligations in the area of retiree health benefits have limited the ability of employers to terminate or cutback on retiree health benefits. Second, the Financial Accounting Standards Board (FASB) has taken steps to require more complete disclosure of employers' liability for these benefits. Third, recent cutbacks in the Medicare program have increased employers' costs in providing retiree benefits and many employers feel this trend will continue. Fourth, for many companies, the ratio of retirees to active workers will increase sharply in the future. If retiree benefits continue to be funded on a pay-as-you-go basis, their costs as a percent of payroll will increase, perhaps to unacceptable levels.

Impact of DEFRA on Pre-funding

It is ironic and unfortunate that just as employers are beginning to understand the extent of their retiree benefit obligations and thus the need to pre-fund, Congress has taken steps to discourage that practice. Specifically:

- Starting next year, income on post-retirement health benefit funds will no longer be deductible and thus will be subject to current income tax; and

- In funding post-retirement benefits, employers will be prohibited from assuming any increase in medical costs in the future, despite the unfortunate history of medical cost inflation.

The impact of these tax law changes on an employer trying to decide whether to mitigate the future cost of retiree benefits by pre-funding can only be fully appreciated by analyzing the level of contributions which pre-DEFRA and post-DEFRA rules allow.

This analysis is graphically illustrated in Exhibit 1. We assumed that an employer desires to pre-fund his retiree benefit obligations and the cost per employee is currently $500 per year. These costs are further assumed to increase at a medical care inflation rate of 10 percent per year and amounts contributed annually to fund benefits earn a rate of interest of 10 percent per year. The exhibit shows the allowable contribution levels permitted pre-DEFRA and post-DEFRA for an employee age 40.

Prior to DEFRA, the employer would have been allowed to establish a tax deductible funding mechanism which calls for level annual payments based on reasonable assumptions with respect to future health care inflation, and he would not be taxed on income earned by the fund. When an employee reaches retirement age, the fund would be sufficient to pay the employer's obligation to provide the promised health benefits over the retiree's expected lifetime. Moreover, because the employer made level annual payments into the fund, the cost would be more easily budgetable. And because the liability for retiree health coverage, which is a cost of doing business today, would be charged against today's revenues, the employer would not have the potential for adverse impact on his competitive position in the future.

Under DEFRA, however, the maximum contribution permitted in the early years of a funding program is substantially lower than the amount that is actuarially required on a level funding basis. For example, in the first year of the funding program illustrated in Exhibit 1, only about 5-10 percent of the true actuarial cost may be funded on a tax deductible basis. Employers who fund on a prudent basis consistent with actuarial principles will thus be denied deductions for the bulk of their contributions.

Employers who fund only as allowed by DEFRA will be faced with steadily increasing costs. Thus, the cost of post-retirement benefits will represent an ever increasing burden to employers, just as would be the case if no pre-funding had been undertaken.

Exhibit 2 illustrates another major problem with pre-funding under DEFRA rules. This exhibit shows the accumulated funding levels that would result from the contribution levels depicted in Exhibit 1. The maximum amount that may be funded at retirement for an employee will represent only a portion (about 60 percent in the example) of the amount needed to fund the employee's post-retirement health benefits. The fund would be exhausted by the time the employee reaches age 74. The employer will, therefore, have to continue funding in some way after an employee retires or continue on a pay-as-you-go basis after funds are exhausted. This prospect will discourage employers from any consideration of pre-funding of these valuable but expensive benefits.

In addition to the problems of sharply escalating costs and inadequate funding levels which result from DEFRA's funding limitations, the employer gains no tax advantage whatsoever by pre-funding retiree medical benefits, despite the current deduction he receives for the pre-funding contribution.

To illustrate this point, consider an employer who contributes $100 to a post-retirement health benefit fund that earns 10 percent interest. The interest earnings will be taxable to the fund under DEFRA. The after-tax earnings of the fund are thus 5.4 percent per year and would generate a fund balance of $130.07 after five years, which could be applied to retiree health benefits.

In this example, the employer's after-tax cost of the $100 fund contribution is $54, since the $100 is currently deductible. Thus, it costs the employer $54 after taxes today to fund benefits of $130.07 due five years from now.

Alternatively, the employer could deposit the $54 in a taxable bank account or security that will earn 10 percent annually before taxes. Again, the after-tax earnings rate is 5.4 percent so the bank account balance will be $70.24 five years from now. In the fifth year, the employer pays the benefits of $130.07 and receives a tax deduction for that amount, producing a tax "savings" of $59.83. The after-tax cost in the fifth year is therefore $70.24 which is exactly the balance in his bank account. Thus, the $54 invested today will be sufficient to fund the after-tax cost of $130.07 in benefits due five years from now.

It is clear, then, that the employer receives no tax advantage for pre-funding post-retirement health benefits. Given the equality of after-tax costs, the employer actually has an incentive not to pre-fund. The employer who retains access to the funds would have added flexibility and would not be subject to the DEFRA's numerous restrictions on allowable levels of funding, including the potential of a 100 percent penalty tax on any assets reverting to the employer.

Conclusion

The available data concerning the scope of benefits being provided by private employers and the future liability which these benefits impose, clearly indicate that some form of pre-funding is the only prudent course of action. We believe that public policy should encourage employers to pre-fund these benefits. We have examined the impact of the law both pre- and post-DEFRA and unfortunately conclude that the actions taken by Congress in adopting DEFRA in 1984 actually discourage pre-funding and are thus counterproductive and shortsighted.

Public policy as embodied in the pre-DEFRA law was reasonable and responsive not only to the government's need to contain costs for Medicare but also to private employers' desire to provide health benefits for their retirees.

When Congress in 1984 enacted the changes in the tax law affecting benefit funding, its focus was on the important but overly broad goal of "deficit reduction." While some progress towards that goal may have been achieved, the pre-DEFRA policy of encouraging employers to provide and prudently fund post-retirement health benefits was sacrificed.

For two reasons, the prospects are for steadily increasing health care costs for the elderly. First, in its desire to cut the federal deficit, Congress will continue to look for ways to reduce Medicare expenditures. Second, before the end of the century, even at current low rates of health care cost increases, the Medicare Part A program will be bankrupt. Congress will look for private sector solutions to providing adequate health insurance for the elderly.

The policy embodied in DEFRA is shortsighted. The effect of this policy will be to reduce Congressional options in dealing with both the federal deficit and Medicare financing problems. It is certain that growing numbers of retired workers will incur steadily increasing medical care costs in the future. In the absence of current incentives for the private sector to provide and fund these benefits, it is likely that the public sector will need to shoulder this burden in the not-too-distant future.

We believe that if Congress focuses directly on the merits of tax-preferred pre-funding of benefits, the conclusion will be reached that pre-DEFRA policy should be reinstated.

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EXHIBIT 1

COMPARISON OF ALLOWABLE CONTRIBUTION LEVELS FOR FUNDING POSTRETIREMENT MEDICAL BENEFITS FOR EMPLOYEE AGE 40

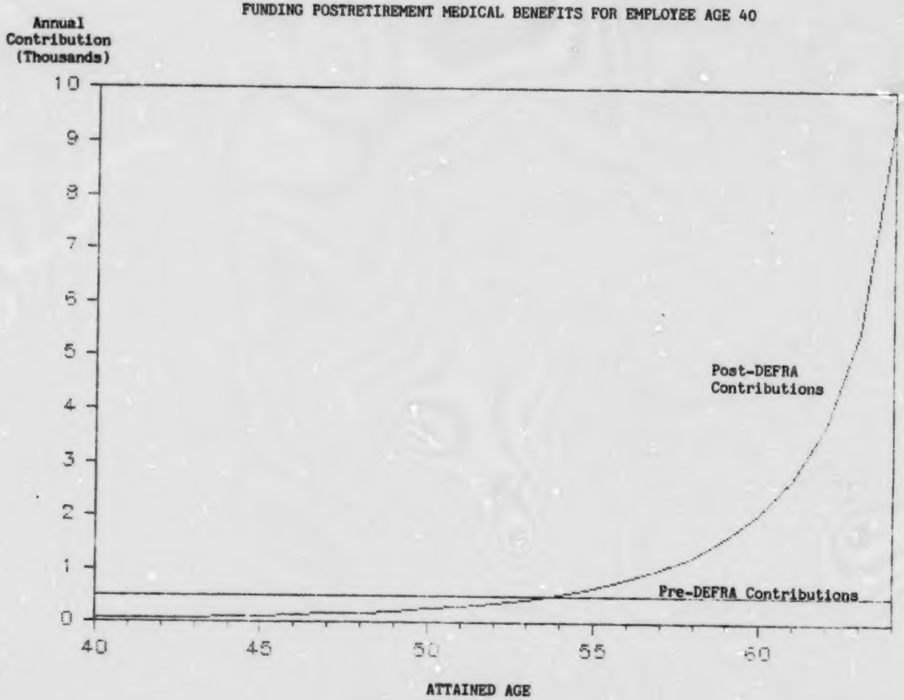
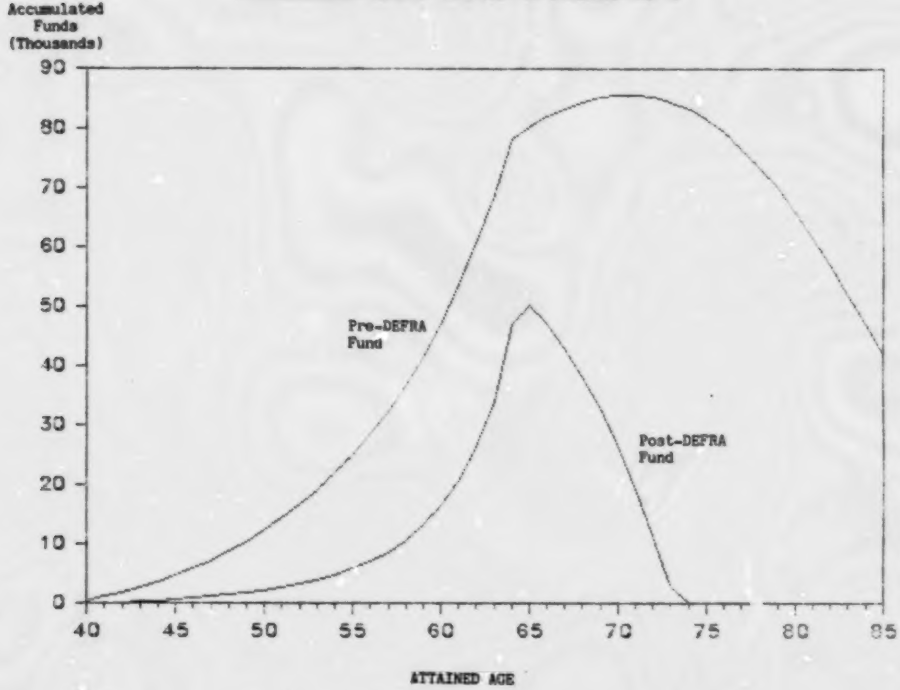


EXHIBIT 2

COMPARISON OF ALLOWABLE FUNDING LEVELS FOR

POSTRETIREMENT MEDICAL BENEFITS FOR EMPLOYEE AGE 40



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EMPLOYER-PAID RETIREE HEALTH INSURANCE: HISTORY AND CURRENT ISSUES

Statement of

Deborah J. Chollet, Ph.D.
and
Robert B. Friedland, Ph.D.*

Hearing before the

United States Senate Committee on Finance
Subcommittee on Savings, Pensions, and Investment Policy

September 9, 1985

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* The authors are Research Associates of the Employee Benefit Research Institute.

The views expressed in this statement are solely those of the authors and should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff.

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EMPLOYER-PAID RETIREE HEALTH INSURANCE:
HISTORY AND CURRENT ISSUES

by

Deborah J. Chollet, Ph.D.
and
Robert B. Friedland, Ph.D.*

Employer-paid retiree health insurance is a common benefit promised to employees of medium-size or large establishments in the United States. In 1984, 57 percent of all regular full-time workers in medium-size and large establishments participating in a health insurance plan were promised retiree health insurance. The cost of coverage promised these workers will be at least partly paid by the employer, usually on a current basis. That is, employers who offer retiree benefits seldom contribute against their accruing liability during the employee's working career.

No data exist that indicate how commonly retiree health insurance is promised to workers in smaller establishments. Available evidence, however, suggests that retiree health insurance for workers in smaller establishments is rare.[1]

History

Retiree health insurance appears to be predominantly a post-Medicare phenomenon. Although no data track the emergence of retiree health insurance as an employee benefit, anecdotal evidence suggests that few employers provided retiree health benefits in the 1950's. The Medicare debate in the early 1960's, however, brought to the attention of American workers the high cost of post-retirement health care relative to the modest incomes of most retirees, probably raising the demand for retiree health insurance as a benefit. The advent of Medicare benefits in 1966, furthermore, dramatically reduced the cost to employers of offering retiree health insurance, since Medicare would pay a large share of retirees' hospital and medical bills. Employer liability for retiree health care costs, although probably substantial, is secondary to Medicare.

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* The authors are research associates of the Employee Benefit Research Institute. The views expressed in this statement are solely those of the authors and should not be attributed to the Employee Benefit Research Institute, its officers, trustees, sponsors, or other staff.

The acceleration of health care costs in the 1970's markedly raised employers' health insurance costs for both active workers and retirees. Between 1965 and 1983, total spending for health care in the United States rose from $43 billion to $355 billion. The cost of hospital care rose three times faster than the cost of other consumer goods and services, increasing six-fold between 1965 and 1983. The cost of physician care also grew faster than other goods and services, more than tripling over that period. In 1983, 14.1 percent of these costs were financed by private insurance, principally by employer group plans. By comparison, the federal government financed 17.3 percent of personal health care spending in 1983.

Health care spending by and for the elderly has risen faster than spending for any other population group in the United States. In 1984, per capita personal health care spending for persons age 65 and older was, on average, 2.66 times the level of per capita personal health care spending for the population as a whole.

Despite the rapid increase in health care costs, particularly for the elderly, many employers did not focus on the rising cost of their obligations to current and future retirees. Reasons for this are many. Typically, employers do not distinguish between the cost of health insurance benefits for retirees and the cost for active employees. Employers usually measure health care costs only in terms of current employees (or equivalently, as a percent of payroll). Low ratios of retirees to active employees throughout the 1960's, and the declining average age of the workforce, served to mask the rising cost of retiree health benefits. Since neither law or accepted accounting practice requires employers to recognize accruing liability for nonpension retirement benefits, employers were able to ignore the mounting current and future cost of health insurance for retirees.

Continued growth in the cost of employer plans, coupled with slowing inflation and reduced profits, has led employers to focus closely on sources of cost increases. In 1983, employer payments for health insurance reached 4.6 percent of payroll, compared to only 3.6 percent in 1979 (see Table 1). For firms that offer retiree health insurance benefits, part of this growth is explained by an increase in the ratio of retirees to active workers as more workers were encouraged to take early retirement during the recession.

Types of Employer-Paid Retiree Health Insurance

Employer-provided health insurance plans for retirees are of three general types, defined by their relationship to Medicare. The first type simply coordinates benefits with Medicare. These plans, called "coordination of benefits" or COB plans, pay beneficiaries the lesser of either (1) the plan benefit calculated without regard to the Medicare reimbursement, or (2) the covered expenses under the plan less the Medicare payment. A second type, "exclusion" plans, subtract Medicare payments before applying the plan's deductible and copayment provisions. The third type, and probably the most common, are "carve-out" plans. Carve-out plans reduce plan reimbursement by

Table 1

Employer Contributions to Health Insurance[a], and as a Percent of Wages and Salaries, 1960-1983

Year	Health Insurance Contributions (amount in billions)	Health Insurance Contributions as a Percent of Wages and Salaries
1960	$ 3.4	1.3 %
1965	5.9	1.6
1966	6.4	1.6
1967	6.9	1.6
1968	8.4	1.8
1969	9.9	1.9
1970	12.1	2.2
1971	13.7	2.4
1972	16.2	2.6
1973	18.0	2.6
1974	20.7	2.7
1975	24.0	3.0
1976	28.8	3.2
1977	34.5	3.5
1978	39.3	3.6
1979	44.2	3.6
1980	49.8	3.7
1981	57.3	3.8
1982	65.7	4.2
1983	76.5	4.6

SOURCE: U.S. Department of Commerce, Bureau of Economic Analysis (1981, 1983, 1984).

[a] Excludes employer contributions to Medicare.

the amount Medicare pays. In general, carve-out plans result in the lowest plan cost, and the highest beneficiary cost of the three types.[2]

Medicare costs are not directly affected by the type of plan offered. However, by minimizing beneficiary cost-sharing, coordination of benefit plans in particular may encourage higher utilization of Medicare-covered services. Conversely, carve-out plans preserve the cost-sharing incentives of the employer's active worker plan, although they reduce the cost-sharing imposed by Medicare.

Trends in Employer-Paid Retiree Health Insurance

EBRI tabulations of survey data collected by the Bureau of Labor Statistics indicate that the prevalence of retiree health insurance benefits in medium-size and large establishments may be declining. In 1980, 59.6 percent of employees in medium-size or large establishments who participated in a health insurance plan were promised continuation of employer-paid coverage after retirement. In 1984, 56.6 percent of these employees were promised health insurance after retirement.

The decline in retiree health insurance promised to workers may result from (1) employers simply withdrawing the benefit, or collective bargaining that trades retiree health insurance for higher wages, some other benefit or reduced layoffs; (2) the erosion of defined-benefit pension coverage which is commonly the basis for continued health insurance coverage; or (3) a redistribution of the workforce into employment that does not offer continued coverage. The significance of each of these factors in explaining lower rates of retiree health coverage promised to current workers has not been investigated.

In any case, post-retirement health coverage faces an uncertain future. At least four major factors may discourage employers from either establishing health coverage for future retirees or expanding existing coverage. These factors include:

- the prospect of action by the Financial Accounting Standards Board (FASB) to require that unfunded liability for post-employment health and welfare benefits be disclosed;
- current tax law;
- recent and expected changes in Medicare coverage; and
- recent litigation over the rights of retirees to promised health insurance benefits.

(1) Disclosure. Federal law requires that qualified pension plans under ERISA be funded. Employers receive tax deductions for contributions to a qualified pension trust fund, and investment income to the trust receives favorable tax treatment. In contrast, retiree health and welfare benefits do not have to be funded, and generally are not funded. Instead, employer payments for retiree health coverage are treated as operating expenses in the year in which the benefits are paid.

In a statement issued in November 1984, FASB established employers' responsibility to provide information about post-employment health and welfare benefits as a footnote of their financial statements. In itself, this is not a significant change in accounting practice, however, the current costs of these benefits are indicated and included in the calculating of net income. Nevertheless, FASB's position is important in that it requires employers to recognize the current cost of retiree benefits separate from the cost of plan benefits for active workers.

Ultimately more significant, however, may be the issue still under consideration by FASB: requiring that employers recognize accruing unfunded liability for retiree health and welfare benefits, similar to the way unfunded pension liabilities must be recognized. By most estimates, the unfunded liability for retiree health and welfare benefits is large.

Based on a nonrepresentative selection of employer plans, the National Association of Accountants estimates that unfunded liabilities for retiree health plans could range from 4 to 50 times the amount that employers are now paying annually as current plan expense. Various actuaries who have calculated these costs for clients concur that liabilities can range from 30 to 50 times the current expense level.

One report, involving a relatively new manufacturing company with 5,000 active employees and 80 retirees (40 of whom are eligible for Medicare) measures unfunded liability at 20 times current plan expense.[3] The current cost of retiree health benefits in this firm is $60,000 a year. Using the actuarial rules under consideration by FASB, funding the accrued liability for the health care costs of current and future retirees would require employer contributions of $1.2 million per year.

(2) Tax law. Concurrent with employers' growing recognition of accruing retiree health liabilities, changes in tax law made the prospect of funding these liabilities less attractive. Prior to the Deficit Reduction Act of 1984 (DEFRA), the tax code defined two tax-favored vehicles for pre-funding retiree health benefits: Section 501(c)(9) trusts, called Voluntary Employee Beneficiary Associations or VEBAs; and Section 401(h) trusts. Although no data exist documenting the use of these vehicles, apparently very few firms used either vehicle to fund accruing liability for retiree health benefits. Those that did fund these liabilities, reportedly, most often used a VEBA; virtually no employers use a 401(h) trust.

DEFRA discouraged use of VEBA to fund liability for retiree health benefits in four ways:

- DEFRA imposed nondiscrimination rules for qualified contributions to a VEBA. Contributions for health benefits now are applied against the limits to qualified pension and profit sharing plans to highly compensated employees (Section 415 limits).
- DEFRA established limits for deductible contributions to VEBAs. Under DEFRA, qualified contributions are limited to the sum of benefits paid during the year, reasonable expenses, and a permissible addition to reserves. Without actuarial certification, the safe harbor limit on the permissible addition is 35 percent of the qualified direct cost. The actuarial assumptions must be based on the current medical plan and cannot include any adjustment for inflation.
- DEFRA imposed a 100-percent penalty tax on any disqualified benefit paid from the fund. Disqualified benefits include any assets reverting to the benefit of the employer sponsoring the welfare benefit fund. This means that any excess of funds greater than necessary to cover retiree benefits cannot be recaptured by the employer.
- DEFRA made all reserves held in VEBAs subject to the tax on unrelated business income.

Many benefit experts consider DEFRA's restrictions on using VEBAs to fund retiree health liabilities prohibitive, given competing uses for funds within a firm--many of which receive preferential tax treatment.

Section 401(h) of the tax code defines a potentially important alternative to VEBAs for funding retiree health insurance liabilities. Section 401(h) authorizes tax-exempt employer contributions to health insurance benefits for retirees, their spouses and dependents, and tax-deferred contributions to retiree death and disability benefits.

Data indicating the use of 401(h) trusts do not exist. Actuaries claim, however, that few firms use 401(h) trusts for retiree health benefits. Those that do may limit plan benefits to payment of Medicare Part B premiums.

Employers may avoid Section 401(h) trusts for several reasons:

- The tax code limits employer contributions to Section 401(h) trusts, requiring that the benefits paid by these accounts be "subordinate" or incidental to the retirement benefits paid by the employer pension plan. This limit is interpreted as constraining employer contributions to the trust to only 25 percent of total contributions to retiree benefits, including pension benefits. For many employers, the limit on contributions to a 401(h) trust is too low to adequately fund accruing liabilities for retiree health, death and disability benefits.

- Funds contributed to a 401(h) are entirely separate from the rest of the pension plan. This means that excess funds contributed to a 401(h) cannot be used to fund other costs in the pension plan.

- The nondiscrimination rules applicable to the pension plan are applied to use of 401(h) trusts. Since, prior to DEFRA the use of VEBAs was not governed by nondiscrimination rules, 401(h) trusts may have been a relatively unattractive means to fund retiree health liabilities.

- Since this type of plan is seldom used, employers have no experience with the plans and are uncertain about the technical aspects of 401(h) trusts.

Given DEFRA's restrictions on the use of VEBAs, Section 401(h) plans may receive much more attention from employers seeking to fund liabilities for retiree health benefits. Limits on contributions to these plans and uncertainty about the legislative and regulatory status of any plan established under Section 401, however, may be important factors impeding their use.

(3) Medicare. Recent and expected changes in Medicare are a critical element in the development of retiree health insurance benefits. Changes in Medicare coverage and reimbursement that shift costs to beneficiaries in turn shift costs to employer-sponsored retiree health plans. Observing the financial status of the Part A (Hospital Insurance) trust fund and the rising public cost of Part B (Supplementary Medical Insurance) coverage, employers anticipate that Congress will impose additional cost-sharing on Medicare beneficiaries. In addition, employers are concerned that Medicare will expand

its position as secondary payor, reducing Medicare obligations for employer-covered retirees in the same way that Medicare has reduced its obligations for workers over age 65 covered by an employer plan.

Finally, employers are concerned that the Medicare Prospective Payment System may increase the cost of retiree health benefits, if reduced hospital lengths of stay result in more physician visits or outpatient services covered by the employer plan. While Medicare covers the full cost of inpatient services after the deductible ($400) for the first 60 days of a spell of illness (called a benefit period), Medicare coverage for physician care entails much greater cost-sharing. The cost-sharing for physician care imposed by Medicare is a major source of cost for employer-sponsored retiree health plans.

(4) Recent litigation. The rights of retirees to health insurance benefits--in particular those that were not funded during retirees' working careers--have been the subject of numerous court decisions at the federal level. The decisions are based in contract law and generally define the property rights of retirees to plan benefits.

Court rulings have addressed the rights of new retirees to health insurance and other nonpension benefits as well as the rights of current retirees to continued benefits in various instances of plan termination. Recent decisions have affirmed retirees' rights to the benefits promised them, generating some concern among employers that vesting standards for unfunded retiree health and welfare benefits are being defined in common law. These vesting standards may imply significant employer costs, in some cases exceeding employer costs for pension benefits.

Early court decisions regarding retirees' rights to nonpension benefits, brought under contract law, interpreted those rights conservatively: retirees may be entitled to benefits only while the contract promising benefits is in force and the employer remains in business.[4] The employer may be obligated to provide lifetime benefits to retirees beyond plan termination only if that obligation is clearly assumed in the contract. Furthermore, vesting for retiree health and welfare benefits may not be implicitly defined "outside the contract" in the context of vesting for other retiree benefits such as a pension.[5]

The precedent established by these decisions placed the burden of proving a continuing right to benefits largely on retirees. Retirees whose benefits were terminated were responsible for proving that the employer breached a bargaining agreement clearly obligating the employer to continue benefits, or at least implying intent to do so.

However, given stated or implied intent to provide benefits to retirees, several decisions interpreted the right to retirement benefits broadly. These decisions have defined vesting for retiree health and welfare benefits as implicit in retirement status, unless otherwise defined in the labor agreement. As early as 1960, Cantor v. Berkshire Life Insurance Company[6] established that the employer may not withdraw or terminate the retirement program after the employee has complied with all conditions entitling him or her to retirement rights. Subsequent court rulings have affirmed that opinion.

Other court rulings concerning the continuation of benefits also construed ambiguity in contract language in favor of retirees when evidence of intent was present. In a series of cases since 1967, the courts obligated employers who promised retiree benefits to continue those benefits throughout the retirees' lifetimes. Generally, these findings were based on the absence of contract language to the contrary and on evidence of intent. The circumstances of these cases included, variously, contract expiration and corporate takeover or merger.

The inference of intent in these rulings was in each instance drawn from the particulars of the case. Commonly, the courts considered both failure of the labor contract to address the issue of lifetime benefits for retirees (or ambiguity in contract language) and management's representations that the benefit would continue for life--including oral statements to that effect.

Reconciling these decisions with more conservative legal precedent, at least one court decision specifically rejected a lower court's presumption that retiree health and life insurance benefits are lifetime benefits, absent express contract language limiting their duration.[7] Similarly, another decision included the following remarks:

> "...retiree insurance benefits are [not] necessarily interminable by their nature. [No] federal labor policy identified to this court presumptively favor[s] the finding of interminable rights to retiree insurance benefits when the collective bargaining agreement is silent."[8]

Two recent court decisions upholding retirees' rights to continued health insurance benefits have gained particular attention. These cases were brought under the Employee Retirement Income Security Act of 1974 (ERISA) which governs the funding, vesting, and fiduciary practices of private pension plans. In that these cases were brought under ERISA, Eardman v. Bethlehem Steel[9] and Hansen v. White Farm Equipment Company[10] are departures from the precedent established earlier under contract law. Hansen v. White Farm, furthermore, cited ERISA's failure to define the rights of retirees to nonpension benefits as the basis for common law defining the the respective rights of retirees and employers in modifying or terminating retiree health benefits.

In Eardman v. Bethlehem Steel, Bethlehem Steel was constrained from modifying its retiree health insurance plans to parallel the benefits offered to active employees under a collective bargaining agreement. Similar to earlier cases where contract language was ambiguous, the court ruling requiring Bethlehem Steel to reinstate benefits strongly considered implied intent. The decision was appealed, and in a later settlement, Bethlehem Steel was allowed to establish a substitute "permanent health program" not subject to later modification or termination.

Hansen v. White Farm Equipment Company contested the termination of a noncontributory retiree health plan after a bankruptcy reorganization. The bankruptcy court authorized replacement of the plan with a group plan arrangement financed entirely by participant premiums. Reversing the bankruptcy court decision, the federal district court held that, in excluding welfare benefit plans from the minimum vesting requirements of ERISA, Congress did not intend to permit the unrestricted termination of these plans by employers. Furthermore, the court stated:

> "the modern view concerning benefit plans, under which an employer may not invoke a termination clause to cut off the benefits of a former employee who has properly retired pursuant to the employer's requirements, should be adopted as a rule of common law under ERISA."11

In the absence of legislation clarifying ERISA's protections for health and welfare plan participants, the precedent set by Hansen v. White Farm and earlier cases governs the organization and administration of retiree health insurance plans. In particular, common law has established a general vesting rule for these plans: former employees who properly retire gain a vested right to welfare benefit plans at retirement. An employer may not terminate the plan or alter its provisions unless the employer has reserved the right to do so, and has clearly communicated that right to employees. Ambiguous plan language regarding the employer's right to terminate or alter the plan may be interpreted broadly in favor of retirees.

Furthermore, by extending retirees' rights as a proposed common law principle under ERISA, Hansen v. White Farm invites legislative clarification of ERISA's provisions regarding health and welfare plans. The Hansen v. White Farm decision may be construed as preventing employers from invoking a termination clause in welfare benefit plans for retirees, regardless of how clearly the rights of the employer are worded or communicated to employees, since this right is not otherwise recognized in ERISA's provisions governing pension plans. The precedent established by Hansen v. White Farm differs markedly from earlier precedent under contract law, and may be an important factor in employer decisions to offer retiree health insurance benefits. Moreover, by rescinding, in effect, employers' ability to terminate benefits, Hansen v. White Farm may be an important impetus to funding accruing liability for retiree health and welfare benefits.

Issues in the Coming Debate

Besides limiting the use of VEBAs for funding retiree health insurance liability, DEFRA mandated Treasury to study possible funding and vesting rules for retiree health plans, similar to the rules now governing pensions under ERISA. Funding and vesting, however, are difficult concepts as applied to service benefits like health insurance, since the cost of providing service benefits is much less predictable than the cost of providing a cash benefit like, for example, defined-benefit pension payments.

As with cash benefits, accruing liability for service benefits (measured as the discounted present value of forecasted plan costs) depends on the probability of employees ultimately qualifying for benefits and on the expected lifespan of retirees. Unlike cash benefits, however, future health insurance costs also depend on the long-term rate of health care cost inflation, changes in the delivery of health care, and changes in medical technology. Moreover, survivorship rights under a retiree health plan cannot be factored into the benefit payout in the same way that a pension plan can reduce annual benefits when retirees elect joint and survivors benefits. As a result, survivors benefits can represent a significant net addition to plan costs, and an added source of uncertainty in forecasting these costs. Finally, the possibility of vesting in more than one retiree health insurance plan represents a practical problem in coordinating benefits from multiple plans as well as Medicare, and an additional source of uncertainty in forecasting plan costs.

Preliminary estimates from the U.S. Department of Labor's Office of Pension and Welfare Benefits indicate that aggregate unfunded liability for retiree health insurance benefits may have reached $125 billion in 1983, and may continue to grow by $5 billion each year.[12] Estimates of additional employer spending per year required to meet that liability in 20 years are $10 billion to $15 billion, equivalent to a 13- to 20-percent increase in the average amount spent by employers for health benefits in 1983.

The emerging policy debate centers on the appropriate and prudent financing of retiree health and other nonpension benefits, as well as the rights of retirees to receive these benefits. While federal rules governing the administration of qualified plans may place funding and reporting burdens on employers (potentially discouraging employers from providing retiree health benefits), such rules may also safeguard promised benefits to workers.

The coming debate over appropriate rules, however, should also consider the current and potential role of employer-sponsored coverage in financing health care for the elderly, and the potential advantages and disadvantages of a larger private system of health insurance for the elderly versus a growing public system. Employer plans may be important in protecting early retirees from the high cost of major illness and in ensuring access to health care. For retirees covered by Medicare, especially those with chronic health problems, employer-sponsored health coverage helps finance substantial out-of-pocket expenses and represents an important supplement to pension income--one that may exceed the value of many retirees' pension plans.

If a larger private system of health insurance for the elderly is to be encouraged, several related issues must be addressed. These include the relative merits of an employer-based system of coverage, versus a more individualized system such as the proposed dedicated individual retirement accounts (sometimes called medical IRAs), specifically earmarked for the purchase of health care or health insurance in retirement. They also include the willingness of Congress and the Administration to sustain the near-term revenue loss implied by tax policy to encourage an greater private insurance coverage among retirees. Possible reductions in the fiscal burden of Medicare and Medicaid spending for the elderly, however, are an important offsetting consideration. Possible long-term reductions in public spending enabled by private coverage should be weighed carefully against the near-term cost of aggressive tax policy to encourage private health insurance coverage among retirees.

ENDNOTES

[1] The 1977 Battelle suvey of Employment Related Health Benefits in Private Nonfarm Business Establishments in the United States (conducted under contract to the U.S. Department of Labor) provides the only available information on the health insurance coverage offered by small establishments. Although the survey did not question respondants about retiree health insurance benefits in particular, responses to a question about continued coverage in any circumstance other than layoffs suggest that small establishments rarely continue coverage for retirees.

[2] The following hypothetical claim and plan illustrate the differences among these methods in plan and beneficiary cost:

- the medical expenses covered under the plan are $1,100;
- Medicare pays $600 of the $1,100;
- the plan is comprehensive with a $100 deductible and 80 percent coinsurance.

The COB plan, absent Medicare, would pay $800 (.8 x ($1,100 - $100)). However, since covered expenses less the Medicare payment are $500 (1,100 - 600), a smaller amount, the plan pays $500. In this plan, the beneficiary pays nothing.

The exclusion plan would pay 80 percent of covered medical expenses (that is, the amount not paid by Medicare: $1,100 - $600 = $500), less the plan deductible. In this case, the plan would payment would be $320 (.8 x ($500 - $100)). The beneficiary would pay $180 ($1,100 - $600 - $320).

The carve-out plan would pay $800 (.8 x ($1,100 - $100)), but since Medicare pays $600, the plan will pay $200. The beneficiary pays $300.

[3] William M. Mercer - Meidinger, Inc., "Understanding the Cost of Post-Retirement Medical Benefits" (New York: William M. Mercer - Meidinger, Inc., May 1985), mimeo.

[4] *Oddie v. Ross Gear & Tool Co.*, 305 F. 2d 143 (6th Cir.) *cert. denied*, 371 U.S. 941 (1962); *UAW v. Robertshaw Controls Co.*, 405 F. 2d 29 (2nd Cir. 1968); *Burgess v. Kawneer Co.*, Memorandum Opinion No. K77-487 CA8 (W.D. Mich. 1977); *Turner v. Teamsters, Local 302*, 604 F. 2d 1219 (9th Cir. 1979); *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742, (E.D. Mich.) undated *Slip op.*; *Metal Polishers Local No. 11 v. Kurz-Kasch, Inc.*, 538 F. Supp. 368, 110 LRRM 3319 (S.D. Ohio 1982); *UAW v. New Castle Foundry*, 4EBC 2455 (S.D. Ind. 1983); *UAW v. Roblin Industries, Inc.*, 561 F. Supp. 288 (W.D. Mich 1983); *Policy v. Powell Press Steel Co.*, Case No. C82-24024, *Slip op.* (N.D. Ohio 1984); *Struble v. Welfare Trust Fund*, F. 2d, 116 LRRM 2980 (3rd Cir. 1984); *Bomhold v. Pabst Brewing Co.*, (No. 83-1327, July 6, 1984).

[5] In *UAW v. Houdaiville*, the court found that the continuation of some benefits for which retirees were vested did not implicitly obligate the employer to continue health and life insurance benefits for retirees beyond the termination of the labor agreement. *UAW v. Houdaiville Industries, Inc.*, Case No. 5-70742, (E.D. Mich.) undated *Slip op.*

[6] *Cantor v. Berkshire Life Insurance Co.*, 171 Ohio St. 405, 171 N.E. 2d 518 (1960).

[7] *UAW v. Cadillac Malleable Iron*, 728 F. 2d 807 (6th Cir., 1984).

[8] *UAW v. Yard-Man, Inc.*, 716 F. 2d 1476 (6th Cir. 1983), *cert. denied,* 104 S. Ct. 100 2 (1984).

[9] *Eardman v. Bethlehem Steel Corp.*, F. Supp., 5 EBC 1985 (W.D. N.Y. 1984).

[10] *Hansen v. White-Farm Equipment Co.*, No. C82-3209 ((N.D. Ohio Sept. 20, 1984).

[11] *Ibid*.

[12] Julie Kosterlitz, "'Disaster' Stories May Spur Congress to Protect Health Benefits for Retirees," *National Journal* (July 27, 1985), pp. 1743-1746.

SPBA SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS
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Testimony of the Society of Professional Benefit Administrators (SPBA)
by Executive Director Frederick D. Hunt, Jr.

U.S. Senate Committee on Finance
Subcommittee on Savings, Pensions & Investment Policy

Hearing on Retiree Health Benefits
July 29, 1985

The Society of Professional Benefit Administrators (SPBA), founded in 1975, is the national association of independent third party contract benefit administration firms. It is estimated that one third (1/3) of all U.S. workers are covered by employee benefit plans administered by such firms.

SPBA members operate much like independent CPA or law firms...providing continuing professional out-of-house claims and benefit plan administration for client employers and benefit plans. Most of the plans employ at least some degree of self-funding. Client plans include those sponsored by corporations of all sizes, associations, and union/management jointly administered Taft-Hartley multi-employer plans.

SPBA membership has been growing consistently at an annual rate of 100%... with a current roster of almost 320 member firms. Similarly, SPBA members have seen the market for their services also expand rapidly...in large part because of the leading role SPBA members have played in successful health cost containment efforts and cost-efficient administration techniques for pension and health benefit plans.

Vast numbers of America's retirees and their dependents will probably soon lose their private health insurance coverage. The culprits responsible for this loss are the Congress of the United States and the Administration.

Prior to 1984, an ever-increasing number of retired workers and their dependents were receiving free or subsidized health insurance coverage. Sometimes it was total coverage similar to that offered active workers, and sometimes the retiree coverage was coordinated with Medicare. In any case, older Americans could expect a much more secure future...with the knowledge that their medical bills for short and long-term care would be paid. Also, America's public health coverage system was saved billions of dollars because retirees had private coverage.

In 1984, Congress and the Administration passed DEFRA (the Deficit Reduction Act of 1984). For the over-40% of Americans covered by self-funded plans, DEFRA was a crippling blow to retiree health coverage. It prevents (or at the very least grossly compli-

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cates) employers' efforts to set aside money during an employee's working years for his retiree coverage. Not to adequately pre-fund is fiscally irresponsible. It is the kind of fiscal irresponsibility that the Congress was simultaneously reversing in the Social Security program...which now more adequately pre-funds.

Frankly, with this foolish Government edict, an employer must either be very sure of his future cash-flow, and/or terminate the coverage for retirees. The termination of coverage is not to be hard-hearted. There are already legal cases in which retirees say that an employer promised or implied retiree coverage...and employers point to DEFRA and say that without adequate pre-funding, they cannot promise or provide such coverage. This is both a blow to employee morale...and self-defeating national policy. **It merely shoves more Americans onto the already over-burdened public programs** such as Social Security, Medicare, Medicaid, VA military hospitals, and state/local welfare.

To provide a one-two punch...to be doubly sure that retirees' private health insurance coverage is terminated, Congress and the Administration have increasingly adopted "cost-shifting"...government-promised services to now be paid by private employee benefit plans. Every time you hear OMB and your colleagues in the Congress talking about "saving millions & billions"...you should realize that **what they really mean is that Uncle Sam will pawn off his costs onto the private sector.** For instance, before the Congress right now is a proposal to shift the cost of "free" Veterans Administration medical care (which was promised to American vets as part of their compensation for service)...onto the private plans. VA would bill private plans for the "free" service...with the private sector not having any way to enforce cost-containment or auditing procedures.

The VA cost-shift is not alone. You have already made Medicare (promised to those over 65) secondary payor to private health insurance plans. Thus, **an employer who covers workers over 65 and/or retirees over 65 is actually penalized by Congress** for including the older person in the private plan. The logical answer is to drop coverage for retirees and dependents, and thus not be penalized by Congress. Of course, dropping coverage for older workers is bad national policy...but that is what you are forcing unless you begin to listen more closely when groups such as SPBA explain the cause-and-effect which you are setting off. In the case of DEFRA and the cost-shifting, we told you so over and over. You must not be overwhelmed and bow down to the staff of the Congress and Administration whose only job is to jiggle financial estimates to meet their own revenue needs. Yes, there may be some revenue gains ...but they will be more than lost by the human and financial loss of providing health coverage for older Americans from some other source.

Mr. Chairman, like you and your colleagues on this committee, our prime concern is for the human effects of legislation...not doubtful revenue projections. We realize that in DEFRA, the avowed purposes of the limits of pre-funding was to stamp out what even the proponents admitted was a miniscule minority of abusive plans.

We begged that the Congress "not throw out the baby with the bath water" and "not use a baseball bat instead of a fly swatter." Even those who understood our warnings told us to "calm down, it can be fixed later". Mr. Chairman, we at SPBA think that leaving America's elderly with this cancer of their coverage while the system wakes up to what it has done is cruel and foolish. We urge you to immediately begin the process to remedy this situation of limits to prefunding and cost-shifting, and we are eager to be of whatever service we can. As you can tell from this statement, **we will not give you gobbledygook.** We will tell you like it is. As the independent administration firms for the employee benefits of 1/3 of all Americans, we have both the independence and the scope to lend useful candor to your considerations. Please feel free to call on us.

Washington Business Group on Health

RETIREE HEALTH BENEFITS:
ISSUES AND OPTIONS

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September 9, 1985

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Health benefits for retirees represent one of the fastest growing, though relatively unexamined, costs of doing business today. Employers began to offer post-retirement benefits a number of years ago as a low-cost benefit given that Medicare picked up a substantial share of the costs. The growing number of retirees, particularly early retirees who are not yet eligible for Medicare, together with the escalating public and private liabililty for retiree health benefits, has focused attention on the adequacy of post-retirement benefit funding.

In addition, certain accounting, legal and legislative developments have complicated the issue. The Financial Accounting Standards Board (FASB) is currently studying whether corporations should recognize the liablity for future retiree health benefits on corporate balance sheets. FASB has already required corporations to describe their retiree health benefit plans, including accounting procedures and cost information, in 1984 financial report footnotes. From a legal perspective, the need to contain health costs has prompted some financially strapped employers to attempt to reduce or eliminate health benefits for current retirees. Court arguments filed on behalf of retirees have focused on the implied or stated employer promise to provide unaltered medical benefits for life. Finally, the Deficit Reduction Act of 1984 changed the incentives for an employer to pre-fund retiree health benefits through a welfare benefit plan. In summary, employers are increasingly faced with signals implying considerable financial liability for current and future retiree health benefits, while feeling constricted by funding options to accomplish that goal.

A survey conducted by the Washington Business Group on Health in early 1985 sought to gather information on the nature and extent of retiree health benefits among large corporations. The survey found that 95% of the 131 respondents offered medical coverage for retirees over age 65 and 98% offered coverage to retirees under age 65. The predominant type of plan for the over-65 retiree was a Medicare carve-out in which the corporation's normal plan payment was reduced by Medicare payments. Slightly over half of the over-65 plans were available to all corporate retirees and required no premium sharing. All of the responding companies with retiree benefits extended those benefits to a retiree's spouse as well, thereby increasing the number of older adults covered by the plans.

Only 5% of the responding companies pre-fund retiree health benefits. This is consistent with other survey findings conducted by a number of benefit consulting firms. The WBGH survey tried to gauge employer reaction to mandated pre-funding by asking what effect it would have on the level of benefits offered. Forty-nine percent of respondents indicated they would continue retiree health benefits as currently offered, 24% volunteered a "don't know" response, 18% said they would scale down benefits, 3% offered other actions and 1% said they would discontinue benefits.

Just over three-quarters of the surveyed companies reported that they account for retiree health benefits separately from active employees, perhaps reflecting the effect of the recently implemented FASB disclosure statement. When asked about the long-term impact of their retiree benefit plans, only 40% of the respondents reported conducting any financial analysis to measure the future liability of the plans. Most of the companies (79%) who have not yet looked at these costs, however, plan to do so in the near future.

Finally, employers were asked about their right to amend or terminate their post-retirement medical benefits for current retirees. An overwhelming number of companies (81%) felt they retained that right. In another section of the survey, however, it appeared that companies were taking a "wait-and-see" attitude in light of current court cases. When asked what cost containment strategies were currently implemented with reference to retirees as compared to active workers, corporate benefit directors seemed more cautious about increasing cost-sharing for retirees.

Little legislative or policy analysis has been conducted as to the respective roles of the government, employers and older individuals themselves in financing post-retirement medical benefits. Traditionally Medicare has played the primary role in providing health benefits for retirees. A recent report from the Medicare Board of Trustees, however, estimated that under moderate economic conditions the Medicare Hospital Insurance Trust Fund would remain solvent until 1998, under poor conditions the fund could go broke by 1992. In addition Medicare only covers 49% of the health care expenditures of the elderly, leaving an average out-of-pocket cost of $1,059 per person in 1984.

An employer currently offering retiree health benefits views the Medicare landscape with some concern. Having recently assumed the role of first payer of benefits for workers & their spouses over 65, employers are fearful that all retirees will ultimately become their primary responsibility with Medicare as a secondary payer.

Pre-funding retiree health benefits represents another problem area. Given the direction of FASB and current legal decisions, there seems to be increased corporate interest in pre-funding retiree benefits. As will be futher discussed, however, pre-funding mechanisms are limited and the imposition of minimum standards, vesting requirements and other restrictions which might accompany tax incentives to pre-fund retiree health benefits are distasteful to many employers. Predicting the future costs of medical care in an era of rapid technological change will be a major difficulty. In addition, one could argue that many companies which might accept the future financial liability for retiree health benefits may not in fact be operational in the near or long-term future. The current financial difficulties of the Pension Benefit Guaranty Corporation may be instructive in this area.

From a government perspective, again the issues are multi-faceted. The current federal emphasis on private sector initiatives would seem to encourage employer-sponsored post-retirement medical benefit programs. On the other hand, the provision of tax incentives to pre-fund those benefits will be heavily scrutinized in an era of tax reform and increasing budget deficits.

From an individual retiree perspective, the provision of retiree health benefits can be viewed from both a current and future vantage point. Retiree health benefits are an important component of a corporate retirement package, particularly in light of the great difficulty older adults experience in finding comparable health coverage at advanced ages. Certainly, the escalating number of court cases in this area also indicates the importance of the issue from a retirees' perspective.

For future retirees, the issues are more complicated. If the goal is to encourage corporations to offer health benefits for future retirees, current disincentives are undercutting that objective. Many companies which were pre-funding are now spending down their reserves and returning to a pay-as-you-go system. Other companies are restricting benefits for future retirees through increased cost-sharing or benefit cut-backs. Finally, some companies would argue that the potential recognition of post-retirement medical benefit liability on corporate balance sheets would seriously affect the financical viability of the company to offer benefits to any worker, let alone to retirees. The extent to which policy decisions force financial trade-offs between groups of beneficiaries in employer plans must be a consideration in identifying solutions.

OPTIONS FOR FUNDING RETIREE HEALTH BENEFITS:

1) "ERISA-ize" post-retirement medical benefits.

In 1974, ERISA (Employee Retirement Income Security Act) was passed to establish participation, funding and termination standards for private pension plans. The extension of ERISA-like standards to post-retirement medical benefits has been discussed as an option. From an individual retiree perspective, this option would be favorably received given that it ensures a future benefit in much the same way pension benefits are now promised. The imposition of standards would also create uniformity, insuring that all employers are subject to the same rules in the provision of benefits.

From an employer perspective,"ERISA-izing" retiree health benefits is problematic from a number of standpoints. First, introducing standards and vesting in effect "locks-in" an employee benefit which employers have traditionally felt was subject to alteration and, in some cases termination if financial constraints dictated. Secondly, employers argue it would be difficult to predict the future with reference to health benefits. What might be a "minimum plan" now, may in fact be totally inadequate in a future marked by increased health costs and changing medical technologies. Employers therefore are reluctant to assume responsibility for an unknown future cost. Thirdly, employers would view the imposition of standards as an administrative burden added to already cumbersome procedures needed to ensure compliance with employee-benefit government regulations. Finally, an unintended consequence of ERISA-izing retiree health benefits might be the ultimate cutback or termination of benefits for future retirees. Whether or not this occurs will depend on the severity of standards imposed, the transition allowed to incorporate change and the ultimate current and future cost to the employer.

2) Reinstate pre-DEFRA incentives for pre-funding retiree health benefits utilizing a Voluntary Employee Benefit Association (VEBA).

A VEBA is a tax-exempt entity under Internal Revenue Code Section 501(c)(9) which provides life, sickness, accident and other benefits to employees, retirees and their dependents. In essence it allows an employer to accumulate funds on a tax-preferred basis to finance a variety of employee benefits. Two restrictions included in the Deficit Reduction Act of 1984 (DEFRA) created disincentives for employer's interested in using VEBAs to pre-fund retiree health benefits: 1) Funds can only be accumulated on a level basis. Therefore, each year's computation of contributions can only be calculated on the assumption that future benefits will have the same cost as those provided to current retirees. 2) Investment earnings on post-retirement medical VEBA reserves are taxable income.

From an employer perspective, many WBGH members have indicated an interest in pre-funding given a tax incentive to do so. VEBAs represent the best known method for pre-funding and, if current restrictions were lifted, the most likely pre-funding mechanism to be utilized. Employers recognize that VEBAs were abused prior to DEFRA by funding questionable employee benefits. They feel, however, that regulations could be written to encourage their positive use while prohibiting unacceptable practices.

From the perspective of federal policy, the extent to which employer tax benefits are offered in an era of tax reform and budget deficit may affect the viability of VEBAs as an option.

3) Pre-funding through an employer pension plan.

Section 401(h) of the Internal Revenue Code permits a pension or annuity plan to provide for the payment of benefits for sickness, accident, hospitalization and medical expenses for retired employees if the plan meets certain requirements with respect to those benefits. Two regulations which are potentially troublesome for employers are: 1)Medical benefits must be subordinate to the retirement benefits provided under the plan (25% of aggregate contributions), and 2) A separate account must be maintained for contributions to provide retiree health benefits. The degree to which subordination of medical to retirement income benefits is a problem for a corporation will depend on the nature of the benefits offered and the demographics of the workforce. Employers with a certain range of pension costs and medical plans which involve retiree contributions may be well-suited for use of a 401(h). The administrative burden of separate accounts would, however, continue to pose a problem, particularly for smaller employers. Finally, many companies do not offer pension plans and therefore would not be able to use a 401(h) approach.

Many employers are unaware of 401(h) as a pre-funding mechanism and an even smaller number are using it to provide for retiree health benefits. Any efforts to encourage its use will need to involve a concerted employer education program.

4) Medical or long-term care IRAs.

Establishing IRAs for medical and/or long-term care needs is an option which encourages future retiree's responsibility for post-retirement medical needs through individual asset accumulation. From an employer perspective, this option would be quite attractive as it lessens the importance of their participation in the provision of retiree health benefits. On the other hand, many argue that IRAs in general have limited value for individuals who cannot afford to set aside funds for future use, or who would only marginally benefit from the tax incentives associated with IRAs. In addition, there is concern that the penalties involved in withdrawing IRA funds may not in fact prevent people from doing so in order to gain a short-term tax advantage. The degree to which IRAs actually provide intended retirement benefits in the future should be monitored to establish the applicability of this mechanism for pre-funding retiree health benefits.

5) Retired lives Reserves

Pre-funding retiree health benefits through retired lives reserves maintained by insurance companies also received favorable tax treatment prior to DEFRA. Rules governing retired lives reserves allow an employer to deduct contributions to a reserve to provide retired employees with group-term life insurance up to $50,000. This reserve is permitted to grow on a tax-exempt basis. The rules also permitted an employer to deduct, generally under the same terms, contributions to a reserve to provide retired employee with health benefits. The calculations for the actuarial reserve, however, are the same as those used for VEBAs: 1)the rules prohibit consideration of projected increases in the current cost and current level of benefits provided by the employer and 2)funds set aside for post-retirement health benefits are not permitted to grow on a tax-exempt basis, but instead are subject to the unrelated business income tax. In effect therefore, an employer is permitted to deduct contributions to a taxable, rather than a tax-exempt trust in order to pre-fund retiree health benefits.

From the employer's perspective, the disincentives created by DEFRA with reference to VEBA also apply to pre-funding through a retired lives reserve. Several employers who were pre-funding through a retired lives reserve are now spending down that account and moving to a pay-as-you-go system.

Discussion of retiree health benefit options which might be considered revolve around the need to ultimately address the question of relative responsibility for retiree health benefits. For example, one option is to downplay the importance of employer-sponsored retiree health benefits and upgrade the Medicare system to better meet the needs of older adults, particularly in the area of long-term care. If tax incentives are likely to be scarce commodities in the near future, would it be better to offer them to families caring for elderly relatives, to corporations developing long-term care insurance plans or to individuals to save for their own needs? Other dimensions of the problem include the need to separate out issues related to *current retirees* who do receive corporate post-retirement benefits from *future retirees* who may or may not receive those benefits. The issues related to corporate early retirees not yet eligible for Medicare-in many cases the most costly class in a benefits program-should be examined separately from retirees who do receive Medicare. Finally, in thinking about tax incentives for employers, it may be useful to identify what is best about each pre-funding option discussed and fashion a new incentive which includes a measure of responsibility for individuals, employers and the government.

The DEFRA mandated studies currently underway in the Departments of Labor and Treasury will flesh out the pros and cons of the various pre-funding options. The WBGH fully intends to circulate that report to our members for comment and would be happy to report our findings in future reports.